

The Impact of Criminalisation on Female Genital Mutilation in England

From the Perspective of Women and Stakeholders

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Abstract

Female genital mutilation (FGM) is a global problem that stems from gender inequality. Increased migration from countries that perform FGM to England has led to the practice travelling across borders. FGM is subject to heightened political debate and media sensitivity in the England and across the Western world.

Debates about FGM often proceed from a universal standpoint that the practice should be prohibited through law. However, the efficacy of FGM legislation is questionable and rarely subjected to scrutiny. Despite implementing a criminal offence of FGM in 1985 and introducing subsequent stringent legal changes, there has not been one conviction for a practice, which remains prevalent in England. A failure to secure convictions for a practice that continues suggests that the law has left women and girls unprotected. To understand why the practice persists in a context in which FGM is criminalised, this thesis aims to address the potential and limitations of social and cultural change through the law.

My qualitative research findings are based on two focus groups each with 11 women from FGM-performing communities and 79 semi-structured interviews with women and stakeholders who are responsible for designing and enforcing FGM legislation, including legal professionals, police officers, Members of Parliament and Members of the House of Lords. I chose to interview these two groups of participants to understand the different perspectives of women subject to the law and stakeholders responsible for enforcing the law.

The interview data shows the importance of an intersectional analysis of FGM that accounts for women's experiences of gender, race, ethnicity, nation, nationality and religion. While FGM is performed upon girls and women's bodies to control their sexuality, women also identified FGM as representative of other identity issues including race, group rights, migrant culture and religion. The data highlights the complex meanings women ascribe to FGM and the challenges they encounter in accessing the criminal justice system. In contrast, stakeholders believe anti-FGM legislation is a means for the state to eliminate 'cultural' violence against women and girls and enforce British values upon minority groups. The findings from the interviews with women and stakeholders revealed a stark divide in the two groups understanding of FGM and their attitudes towards the law. Examining FGM in the context of criminalisation from two different perspectives highlights the core barriers to the enforcement of law.

Dedication

To Mum,

This thesis is dedicated to you because I couldn't have done it without you.

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One of the highlights of this journey was spending a semester at Harvard Law School in the fall of 2015. During this time I was engrossed in the Presidential Elections. I had the privilege of watching Hillary Clinton speak, as well as other leaders from across the world. My fondest memory is spending one sunny Sunday afternoon in the gardens at Yale Law School with Professor Catharine MacKinnon. Hours passed by as we talked feminism, politics and the challenges ahead. People say you should never meet your hero. I'm glad I did.

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Introduction

“They brought this other man to hold me down. I remember just feeling ashamed because they were seeing my private parts. I think that is what I was worried about more than anything. He said, “We are going to give you an injection and everything will be fine. You won’t feel a thing”. I felt everything. I felt the injection. I felt being cut. I felt being sewn.”

Survivor of FGM Leyla Hussein¹

“Over 100,000 women in the UK are living with the consequences and 60,000 are at risk of FGM. We must do more because one girl subjected to FGM, or forced to marry, is one too much... We will make the law clearer... We must raise awareness, challenge social norms and protect those at risk.”

Home Secretary Theresa May²

This thesis examines why female genital mutilation (FGM) persists in a context in which it is criminalised. To answer this research question, this study explores the potential and limitations of social and cultural change through the law in England³. This qualitative empirical research study explores the experiences of women from FGM-performing communities and the attitudes of stakeholders⁴ responsible for designing and enforcing the

¹ House of Commons Home Affairs Committee (2014), page 5.

² Sanghani (22 July 2014).

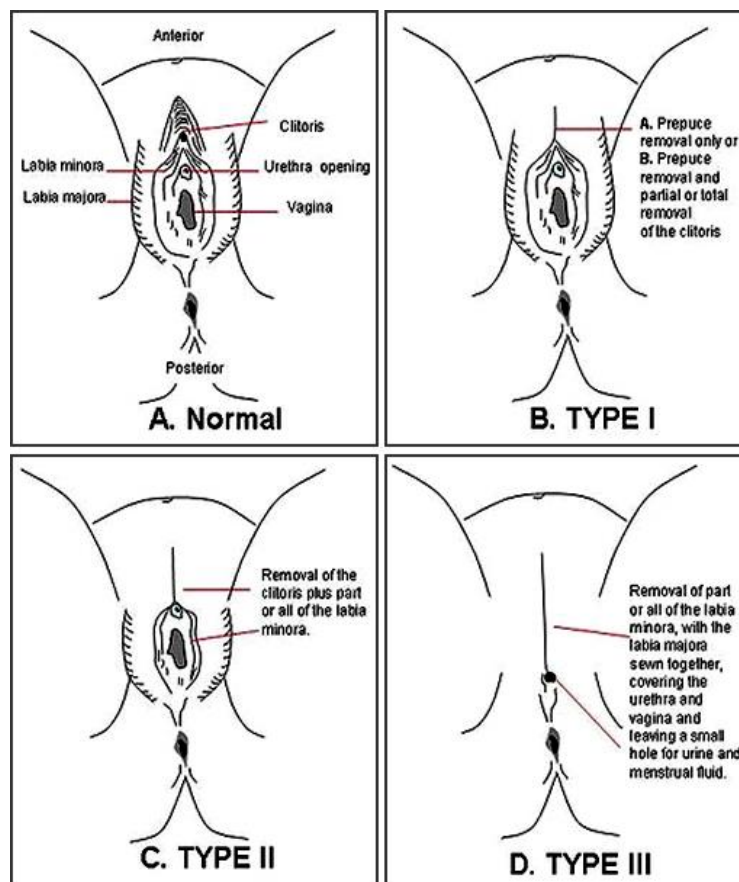
³ This thesis focuses on FGM in England rather than in the UK because the interviews were conducted in England not in Wales, Scotland or Northern Ireland. There are nuances in approaches designed to eliminate FGM across geographical boundaries in terms of funding and policies that are not subject to discussion in this thesis. See Baillot, Murray, Connelly, and Howard (2014) for a report on a Scottish model of intervention for tackling FGM. The paper reinforces the need for empirical research about FGM. I was commissioned by the Northern Ireland Human Rights Commission in 2016 to draft a briefing paper on FGM law in other jurisdictions and make proposals for legislative change, which has yet to be published and thus cannot be cited. Across the UK there is scarce empirical research about FGM and reliable statistics of prevalence rates.

⁴ Stakeholder refers to professionals working with FGM-performing communities and professionals responsible for designing and enforcing the law. They include legal professionals, Members of Parliament, police officers and NGO workers. A list of stakeholders interviewed can be found in Appendix IV.

law. The data shows women and stakeholders' understanding of FGM and the law, which is one of the reasons for the failure of enforcing the law. An intersectional lens is adopted to understand how women's experiences of structural inequalities of gender, race, class, nationality and religion impact upon women's understanding of FGM, stakeholders' response to the practice and the representation of the legal consequences. While there is a political and public commitment to eliminating FGM as evidenced by the quotations above, this study will address whether further policy and legal change can end the practice, or whether alternative approaches must be considered.

Examining the Four Types of Female Genital Mutilation

Eliminating Female genital mutilation, an interagency statement developed by the World Health Organization (WHO) in 1995 and updated in 2008 provides the international anatomical typology of FGM. The WHO identified four types of FGM, which originate from a study conducted by Felix Bryk in 1910 that identified eight types of FGM based partially on his fieldwork in Kenya (Zabus, 2007: 11). This study applies the four types of FGM defined by the WHO.



**There is no image for TYPE IV FGM because it is difficult to physically detect incising of the clitoris or ritual nicking or other practices that do not involve the cutting and removal of healthy genitalia tissue.*

Type I: Partial or total removal of the clitoris and/or the prepuce (*clitoridectomy*). When it is important to distinguish between the major variations of **Type I** mutilation, the following subdivisions are proposed: **Type Ia**, removal of the clitoral hood or prepuce only; **Type Ib**, removal of the clitoris with the prepuce. FGM-performing communities usually refer to type I as *sunna*, which is Arabic for ‘tradition’ or ‘duty’ (Unicef, 2013: 7).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (*excision*). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: **Type IIa**, removal of the labia minora only; **Type IIb**, partial or total removal of the clitoris and the labia minora; **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (*infibulation*). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: **Type IIIa**: removal and apposition of the labia minora; **Type IIIb**: removal and apposition of the labia majora. The seal of the labia results in near complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as deinfibulation (Unicef, 2013: 7). In some cases, the seal of the labia is closed again with reinfibulation. Community members usually refer to Type III FGM as pharaonic circumcision or pharaonic infibulation (Momoh, 2005). It is thought pharaonic refers to the origins of the practice in ancient Egypt (Dorkenoo, 1994: 33).

Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization. Pricking or nicking involves cutting to draw blood, but no removal of tissue and no permanent alteration of the external genitalia (Unicef, 2013: 7). Some communities call this “symbolic circumcision” (Unicef, 2013: 7). Although symbolic

circumcision is still highly controversial, it has been proposed as an alternative to more severe forms of cutting in both African and other countries where FGM is performed (Coleman, 1998; Obiora, 1997; Pediatrics, 2010; Unicef, 2013).

Terminology and Language

Language and who uses it are, of course, politically and epistemologically significant
(Nnaemeka, 2005b: 217).

Choosing terminology to describe these practices is “fraught with political land mines” and one of the most controversial issues (Shell-Duncan & Hernlund, 2000: 6). Attention to language is essential to understanding the political and ideological debates in which FGM is situated (Abusharaf, 2013: 5). Until the 1980s, “female circumcision” was historically used to describe these practices in the international literature (Rahman & Toubia, 2000). However, the growth of the feminist movement and public concern from international health organisations, resulted in objection to the term, as it de-emphasises the severity of the practice by comparing it to the removal of foreskin of males (Shell-Duncan & Hernlund, 2000: 6). The use of “female circumcision” to describe FGM suggests that a parallel can be drawn with male circumcision, which creates confusion about the significance of the practice.

In 1990, the term “female genital mutilation” was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Addis Ababa, Ethiopia (Unicef, World Health, & UNFPA, 1997: 22). In 1991, the WHO recommended the UN adopt the term. From the late 1990s, the term has been increasingly used by international and national agencies (Unicef et al., 1997: 22). A joint statement issued in 1997 by the WHO, UNICEF and UNFPA defined the practices as “female genital mutilation” (Unicef et al., 1997: 6). The joint statement concluded that adopting FGM as the standard term for the practices reinforced the gravity of the act and promoted the abandonment of the practices (Unicef et al., 1997: 5). The term FGM has been “a very effective advocacy and policy tool and has been used in several UN conference documents” (Izett & Toubia, 1999). Anti-FGM advocate Dorkenoo (1994) contends that “any definitive and irremediable removal of a healthy organ is mutilation” (4).

There was some evidence that the term “mutilation” has estranged communities, hindering the process of social change for the elimination of FGM (Unicef et al., 1997: 22). FGM can be considered an offensive term to women who do not regard themselves as mutilated or their

families as mutilators (Rahman & Toubia, 2000). FGM could be considered moral condemnatory language that prejudices women's autonomy to choose the practice (Meyers, 2000: 470). Female circumcision continues to be used by fieldworkers and researchers to show respect for women's understandings of the practice (Leye et al., 2007). Scholars argue that to adopt any other language would show disrespect for women and their cultures and could be an example of cultural imperialism (Meyers, 2000: 469). Scholars contend that any other language than "mutilation" condones the practice and sustains male dominance (Meyers, 2000: 469).

Gunning (1991) proposed the term "genital surgeries" as a value-neutral term, but the term could suggest medical necessity (Shell-Duncan & Hernlund, 2000: 6). Some non-government organisations (NGOs) have adopted the term female genital cutting (FGC), which appears more neutral and sensitive to FGM-performing communities' beliefs (Abusharaf, 2013: 6).

I adopt the official term of female genital mutilation (FGM) throughout the thesis. I use this term because it situates FGM within current political and public discourse. Furthermore, the aim of any research or policy relating to FGM is to eliminate the practice. When interviewing women I used the terms FGM and female circumcision interchangeably, as FGM could alienate those who do not perceive the practice as mutilation (Abusharaf, 2013: 6).

In addition, a debate persists in the feminist literature as to whether "victim" or "survivor" should be used to describe women who have experienced FGM. Victim suggests a lack of agency and autonomy. Such depictions could put further distance between communities and the state. Survivor could be viewed as suggesting women have survived mutilation. Some women reject the label survivor as they view FGM as a normal cultural practice. Survivor is not a term widely used in political or public discourse to describe women who have undergone FGM. However, I occasionally refer to women as survivors in the context of discussing their experiences of FGM. In some cases women attributed the identity of survivors to themselves. In this thesis, I have tried to steer away from using specific labels and have instead referred to women as "women" a value neutral term.

I use the term "FGM-performing community" to refer to a broad category of people whose family originate from countries where FGM is performed⁵. This fluid category includes women from FGM-performing communities who have undergone FGM, women who have

⁵ See report by Unicef (2013) which identifies the countries where FGM is performed.

not undergone FGM⁶, women who did not disclose whether they had been cut, perpetrators and men⁷.

Prevalence of Female Genital Mutilation Internationally and Nationally

Historically, FGM is thought to have originated in southern Egypt or northern Sudan and was practiced by many cultures including the Phoenicians, Hittites and the ancient Egyptians (Rahman & Toubia, 2000: 7). From the 1800s to the 1950s medical practitioners in the UK and the United States performed FGM to cure hysteria, lesbianism, masturbation and other so-called female deviations (Gunning, 1991; Rahman & Toubia, 2000: 7; Sheehan, 1997). A 2012 report in the medical literature shows that a clitoridectomy was performed on a 33-year-old woman for aesthetic reasons in the UK (Veale & Daniels, 2012).

Due to a lack of data collection about FGM worldwide, the exact number of women and girls who have undergone FGM is not known. A report by Unicef (2016), *Female Genital Mutilation/Cutting: A Global Concern*, estimates that at least 200 million girls and women alive today have undergone FGM in 30 countries. Half of the girls and women who have been cut live in three countries – Egypt, Ethiopia and Indonesia. Girls at the age of 14 and younger represent 44 million of those who have been cut. While the practice is nearly universal in Somalia, Guinea, Djibouti and Egypt, FGM only affects one per cent of girls and women in Cameroon and Uganda (Unicef, 2013: 114). The report states that FGM can also be traced to India and Pakistan. However, there are no reliable estimates about FGM prevalence rates in these countries. See Appendix IX for an FGM global prevalence map with percentages of FGM.

The prevalence rates and the types of FGM performed vary according to each ethnic group within every country (Momoh, 2005). It is possible to detect trends in the types of FGM that are performed in various countries. In Somalia, Eritrea, Niger, Djibouti and Senegal, more

⁶ While some women had not undergone FGM, they were able to speak about the practice from their position within an FGM-performing, which supports the practice.

⁷ Gaining access to male participants was an impossible task, as men rarely speak about a practice that is performed on women's genitalia. However, I managed to interview two men. I met one man at an FGM conference and I met the other man through an African cultural community event. Neither was able to put me in contact with other men to interview.

than one in five girls have undergone type III, the most physically invasive type of FGM (Unicef, 2013: 114). However, the most common form of mutilation across the world is type II, which accounts for around 80 per cent of cases (Gordon, 2005). Gordon (2005), a Consultant obstetrician and gynaecologist, states that doctors in Europe see patients with mainly FGM type III.

In England and other Western countries, FGM tends to occur amongst immigrants, refugees and asylum seekers when their families originate from FGM-performing countries. FGM is usually prevalent amongst FGM-performing communities from Somalia, Sudan, Djibouti, Nigeria, Eritrea, Ethiopia and Sierra Leone (Mohammad, 2005). The largest populations of people whose families can be traced to FGM-performing countries tend to reside in London, Bristol, Cardiff, Coventry, Reading, Thurrock, Manchester, Sheffield, Northampton, Birmingham, Oxford, Slough and Milton Keynes (Macfarlane & Dorkenoo, 2014).

In 2014, a study estimated that approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM and 137,000 women and girls born in countries where FGM is performed were permanently resident in England and Wales (Macfarlane & Dorkenoo, 2014). In September 2014, the Health and Social Care Information Centre began collecting data on FGM within England on behalf of the Department of Health and National Health Service (NHS) England to improve the NHS response to FGM and help commission services to support women and girls. However, the statistics are only based on the number of women and girls treated by specific NHS medical practices rather an accurate reflection of the prevalence rates in England.

FGM is commonly performed on girls between the ages of four and twelve as a rite of passage to womanhood (Toubia, 1995b: 9). However, the age FGM is performed varies according to the country, tribe and circumstances and ranges from a few days old to adolescence, adulthood, just before marriage or after the first pregnancy (Momoh, 2005: 2). Gerry Mackie (2000) writes that FGM may be performed at various stages of an individual's life, at infancy, before puberty, at puberty, with or without initiation rites, upon contracting marriage, during pregnancy and after the birth of the first child. Specifically referring to the UK, Dorkenoo (1994) states that girls are most likely to be subjected to FGM between five and ten years of age. However, as the campaign against FGM deepens, Dorkenoo (1994) cautions that parents are cutting children younger to avoid detection (131). Girls may be cut alone or with a group of family members or peers from their community (Rahman & Toubia,

2000: 3). Infibulated⁸ women are often deinfibulated⁹ to enable them to have sexual intercourse after marriage and to give birth to a child. In some cases, women are reinfibulated¹⁰ after birth to leave a small hole (Lightfoot - Klein & Shaw, 1991).

FGM is usually performed by a traditional practitioner, often an older woman, who comes from a family in which generations of women were traditional practitioners (Rahman & Toubia, 2000: 3). In some countries, trained medical practitioners such as midwives, nurses and physicians, have in recent years performed FGM on the “black market” (Toubia, 1995b: 29). According to Dorkenoo, medical practitioners or traditional excisors perform FGM either in the UK or girls are taken to countries of origin or to countries where FGM is medicalised (1994: 131). Girls who are subjected to FGM overseas are usually taken abroad at the start of the school holidays, typically in the summer, in order for them to recover before returning to school. This is commonly known as the “cutting season.”

Health Consequences of Female Genital Mutilation

The health consequences of FGM vary depending on multiple factors such as the type of FGM, the medical experience of the excisor and the medicalised or non-medicalised context in which FGM is performed. The use of unsterile instruments can cause infections after the procedure particularly if the wounded area is contaminated with urine or faeces. While long-term health complications can arise from any type of FGM, types II and III usually result in the severest complications due to the grave nature of the injury.

The possible immediate physical complications of all types of FGM include severe pain, bleeding and haemorrhage, which if not controlled can result in death (Rahman & Toubia, 2000: 8). The most common long-term complications are dermoid cysts in the line of the scar, chronic urinary tract infections, which can evolve and lead to urinary stones and kidney damage and fistulae (Toubia, 1994: 713). Women may suffer pain during menstruation, pain from sexual intercourse and complications during childbirth. Infibulated women usually have to undergo deinfibulation prior to the delivery of the child. If deinfibulation is not performed, the mother and child’s lives could be threatened.

⁸ Infibulated refers to Type III FGM.

⁹ Deinfibulation refers to the practice of cutting open the sealed vaginal opening in a woman who has been infibulated (World Health Organisation, 2008).

¹⁰ Reinfibulation refers to re-sealing the vaginal opening after an infibulated woman has undergone deinfibulation.

While there are few studies on the psychological effects of FGM available, Rahman and Toubia (2000) contend that shortly after undergoing FGM women and girls can experience disturbances in appetite, sleep, mood and cognition. Rahman and Toubia (2000) explain many women and girls experience fear, submission and suppressed feelings of anger, bitterness or betrayal. A study of Boddy (1989) of a community in Sudan shows that FGM had negative effects on self-identity and self-esteem. A tragic irony is that symptoms of depression are labelled as hysteria rather than attributable to FGM (Toubia, 1995: 230).

The issue of how women experience their own sexuality is an area of limited research. According to Rahman and Toubia (2000) available studies suggest FGM interferes to some degree with women's sexual responses. However, this is highly contested and unsupported by reliable and recent empirical work. Growing research shows the practice does not necessarily eliminate sexual pleasure and climax (El Dareer, 1982; Koso-Thomas, 1987; Megafu, 1983; Shandall, 1967). Lightfoot - Klein and Shaw (1991) found that in some cases, infibulated women in Sudan reported pleasurable sex and orgasm. Malmström (2013) found that women who had been cut in Egypt asserted their sexuality and resisted accusations that FGM removes their sexuality. Ahmadu (2000) asserts that many women, including herself, who had sexual experiences prior to FGM, experience either no difference or increased sexual pleasure following the practice. The available research about women's sexual experiences post-FGM challenges leading anti-FGM narratives that the practice is primarily performed to curtail women's sexuality.

Adverse health risks form the main opposition to FGM. Reports of health risks of FGM are not without criticism. Obiora (1997) contends that little attention is given to the original source of medical information, which usually emanates from British colonial surgeons and gynaecologists in the 1930s and 1940s. Instead, the health consequences of some cases of infibulation are generalised to describe the health risks of *all* types of FGM to support the dominant narrative that FGM should be treated as a public health problem (Shell-Duncan & Hernlund, 2000). Obermeyer (1999) argued that much of FGM research is based on a singular anecdote and "despite their deficiencies, some of the published reports have come to acquire an aura of *dependability* through repeated and uncritical citations" (92). The purpose of setting out the diverse views on the health consequences of FGM highlights the polarised views towards every aspect of the practice.

Motivations for Female Genital Mutilation

The reasons for FGM are complex, interrelated and woven into the beliefs and values that various communities uphold (Rahman & Toubia, 2000: 5). FGM is based on a belief system rather than a single factor. Motivations vary within each community that perform FGM. I expand on the motivations for FGM in the literature review and in the empirical data, but for now, I provide short descriptions of the most common motivations for the practice by way of introduction. They include control of women's sexuality, custom and tradition, social pressure and religion. Later chapters explore the intersection of the motivations for FGM with the multiple forms of oppression women experience, such as gender, race, class, nationality and religion. An intersectional analysis allows for an exploration of women's experiences of FGM and the law, which are situated within systems of discrimination.

Control of Women's Sexuality

The most significant reason for FGM is the need to control a woman's sexuality. The meanings attached to women's sexuality depend on the community performing the practice. In patriarchal communities, a family or clan's honour depends on a girl and woman's virginity and chastity (Rahman & Toubia, 2000). FGM is performed to prevent premarital sex, preserve virginity and curtail infidelity on marriage. It is thought that cutting a woman's genitalia would reduce her sexual desire, thus ensuring that she conforms to the role expected of her as a wife and mother. De-emphasising a woman's sexual behaviour is believed to emphasise her reproductive role in producing the next generation (Boddy, 1982; Koso-Thomas, 1987). A woman depends on marriage for economic and social survival, thus she is compelled to undergo FGM or she could be considered unmarriageable (Lightfoot - Klein & Shaw, 1991). Some communities believe that girls do not become women until their genitalia are removed. According to Assaad (1980), many communities believe "that a woman is not fully a woman until her ugly genitalia are removed" (6), while other communities perceive that women's genitalia is masculine and thus undergoing FGM emphasises their femininity. Strong belief systems predicated on preserving FGM create pressure from peers, family and communities to undergo the practice (Toubia, 1995b).

Culture and Tradition

In some communities, FGM is performed as a rite of passage from childhood to adulthood (Gunning, 1999; Rahman & Toubia, 2000). The notion that FGM is a prerequisite for a girl to become a woman ensures the practice is maintained, because FGM is believed to be central

for a girl to perform the roles expected of her as a wife and mother. It can also show a girl's ability to withstand pain in preparation for childbirth. FGM is also regarded as a means of socialising girls to adopt cultural values and pass them on to the next generation. Communities that practice FGM affirm their relationship with the beliefs of the past by continuing the tradition over generations. They also maintain community customs and preserve their cultural identity (Rahman & Toubia, 2000). It can also be a way for migrant groups to indicate their difference from the dominant Western culture.

Social Pressure

Another explanation for FGM that is often cited is social pressure. In communities where most women are cut, family, peers and community members create an environment in which the practice of FGM is performed due to social conformity and expectations (Dorkenoo, 1994; Rahman & Toubia, 2000). The pervasive nature of the practice creates a perception of acceptance and normality. In these circumstances, non-conformity could carry significant social costs. The persistence of the practice is maintained with fear of family and community isolation and prospects of living a life unmarried (Gunning, 1999). Believing that FGM is necessary for social homogeneity ensures the continuity of the practice.

Religious Reasons

Community members usually state religion as a reason for performing FGM. Rahman and Toubia (2000) note that FGM is a cultural, not a religious practice. The practice predates the arrival of Christianity and Islam in Africa and is not a requirement of either religion (Rahman & Toubia, 2000). Today, FGM is practiced by Jews, Christians, Muslims and indigenous religious groups (Toubia, 1995a: 225). FGM is often conflated with Islam. While many scholars proclaim that FGM is not a Muslim practice, the validity of this assertion is a theological debate within Muslim communities (Rahman & Toubia, 2000: 6). It is generally accepted amongst scholars that the Quran, the primary source for Islamic law, contains no explicit endorsement of FGM (Shell-Duncan & Hernlund, 2000). However, debates focus on whether a hadith¹¹ implicitly supports FGM:

“There is a contested Hadith that addresses the practice of female genital cutting directly. It described Mohammed suggesting to a midwife that excision is “allowed” but should not be “overdone” because a more limited cutting “brings more radiance

¹¹ A hadith is the collections of the sayings of the Prophet Mohammed.

to the face... and is... better for the husband"... the *hadith* is contested, however, because the relevant authority is obscure and its genealogy questionable" (Boyle, Songora, & Foss, 2001: 527; Coleman, 1998).

While the validity of this Hadith is highly contested within Muslim communities, some scholars attempt to advocate for the practice along religious lines. Scholars such as Abu-Sahlieh (1994) have attempted to establish that there is no scriptural support for enforcing FGM. However, the absence of scriptural evidence does not necessarily undermine the religious motivation for communities who continue to practice it (Lewis, 1995).

Theoretical Framework

This thesis seeks to explore why FGM persists when the practice has been a criminal offence in England since 1985. The law has clearly not achieved the objective of elimination. It is important to note from the outset that the purpose of this thesis is to further research about FGM in order to eliminate the practice. Dealing with issues of reflexivity, my background is relevant in reflecting on how my position has impacted upon the theoretical and practical design of this thesis¹². I practice as a family and immigration law barrister specialising in violence against women and girls. I have advised NGOs in relation to cases of FGM and I have represented women and girls who have undergone FGM or are at risk of the practice¹³. My experience has driven me towards wanting to understand the practice from the perspective of communities including those that defend FGM. I chose a qualitative methodological approach to allow the participants' voices to be heard through the research. It is rare for stakeholders, particularly in the field of law, to have a thirst for learning about the nuances of prohibited practices within communities. This is one of the reasons why stakeholders struggle with applying an intersectional lens to understand the motivations for performing prohibited practices and the impact of the law upon women's lives.

The core research question of this thesis is why does FGM remain prevalent in a context in which the practice is criminalised. The function of the criminal law is first to prohibit behaviour and practices in society and therefore maintain social control and second, to send a public message that specific behaviour and practices are unacceptable (Ashworth & Zedner,

¹² Reflexivity and ethics are explored further in chapter three, the methodology chapter.

¹³ While I am an anti-FGM advocate, I suspended my own activism and assumed as neutral a position as possible. This allowed me to document and give space to the views of women from communities.

2008). Arguably, the consequences of committing a criminal offence act as a deterrent. This thesis aims to explore why the law has failed to have an impact upon the persistence of the practice. To understand this question, it is important to listen to the voices of women who have undergone FGM, who advocate against the practice and who defend it. Research studies ordinarily proceed without scrutiny of why FGM is impenetrable by the British state and stakeholders. The defence of FGM is not merely about protecting a group right to perform a cultural practice. FGM is representative of other issues of migrant culture, group rights, cultural norms and race.

The intersectional approach of this thesis is to reflect on the recurring themes of women's experiences of identity categories and structural inequalities including gender, race, class, nationality and religion and how these threads of commonality inform women's experiences of FGM. Critical race theorist, Kimberley Crenshaw coined the term "intersectionality" in 1989¹⁴, which involves the analysis of "intrinsically negative frameworks in which social power works to exclude or marginalise those who are different" (Crenshaw, 1991: 1242). Highlighting the intersection of the common modes of oppression and FGM shows the impact different structural inequalities have upon women's lives, their attitudes and beliefs towards FGM, their experiences of working with the police, as well as the barriers to seeking to support¹⁵. For example, a woman's identity as an immigrant could link to modes of resistance to the law and attempts to eliminate the practice. This thesis applies an intersectional theoretical framework to the practice of FGM to analyse how women's experiences of structural inequalities impact on their experiences of FGM, stakeholders' response to the practice and the representation of legal consequences.

As the law's response to FGM is a central part of this study, stakeholders' attitudes and beliefs towards FGM and the implementation of the law provide a valuable insight into why the law has failed to eliminate the practice. Stakeholders responsible for designing and enforcing the law include legal professionals, police officers, Members of Parliament and Members of the House of Lords. An intersectional approach to examining law and policy from the perspective of stakeholders is also relevant to this thesis. This study will explore whether stakeholders recognise broader factors of structural inequalities that impact upon women's experiences of FGM and their experiences of the law. The British state has an

¹⁴ Although Crenshaw coined the term, scholars had already been applying an intersectional analysis.

¹⁵ The theoretical foundation of intersectionality is explored further in the literature review in chapter two.

interest in FGM because criminalising the practice ensures the protection of British values and the enforcement of norms upon ‘other’ communities. The law has been subject to criticism for failing to recognise the diversity of individuals within particular groups, instead regarding them as a homogeneous category (Uccellari, 2008). The failure to recognise the complexity of individuals’ lives and the discrimination they encounter, could account for the law’s failure to eliminate the practice of FGM.

While my position relating to the debates about FGM is to further the elimination of FGM, I recognise that there are a multitude of perspectives towards the practice including defending FGM or sympathising with the practice. This thesis analyses the position of all sides of the debates about FGM and it examines why there is limited dialogue between the different positions. This involves analysing the conflict and tensions between the theoretical positions of feminism, international human rights, cultural relativism and critical race theory. The purpose is to understand the practice of FGM within these diverse theoretical frameworks, which take different positions on the practice. Feminism regards FGM as control over women and girls’ sexuality (Daly, 1990; Hosken, 1979; Walker & Parmar, 1993). International human rights define the practice as a violation of the child’s right to bodily integrity (Bunch, 1990; Coomaraswamy, 2002b). Colliding with these positions is cultural relativism, which often regards FGM as a legitimate cultural practice while Western opposition is perceived as neo-colonial imposition (Ahmadu, 2000; Shweder, 2000). Meanwhile critical race theory identifies the distinctive legal control exercised over ethnic minority women from a racial perspective (Crenshaw, 1991).

Moreover, examining these multiple theoretical positions highlights the intersection of women’s experiences of gender, race, culture, class, nationality and religion. Rarely are divergent academic theories explored within research studies on FGM, as they are treated with mutual suspicion. Scholars usually apply one theoretical frame to their study, to the exclusion of other theoretical positions and an intersectional lens. The purpose of this study is to explore competing theories within the literature review and to apply an intersectional analysis when interpreting the data.

Aims and Research Questions

The overarching research question of this study is why does FGM persist in a context in which the practice has been a criminal offence in England since 1985. To answer this question, I explore women’s experiences of FGM in England, women and stakeholders’

attitudes and beliefs towards the criminalisation of the practice and the potential and challenges of social and cultural change through the law. There are three further research questions that stem from the overarching research question and each question is addressed sequentially in empirical chapters four, five and six:

1. What are the motivations for continuing the practice of FGM?
2. What are women's and stakeholders' attitudes and beliefs towards the criminalisation of FGM and what impact have the laws had on the dynamics of the practice?
3. What are the barriers to the law deterring and eliminating FGM?

Original Contribution

There is a dearth of research on why FGM persists when the practice is a criminal offence. Research tends to focus on the practice of FGM from one narrow lens of sociology, anthropology, medicine, law or politics. There are limited studies exploring the interrelationship between FGM and the criminalisation of the practice from a socio-legal perspective. My background as a barrister and PhD candidate in the Sociology Department has allowed for the fusing of two related spheres together.

The sparse literature on FGM rarely cites empirical research and when research is cited it tends to be outdated and relate to small-scale studies. This thesis aims to provide a valuable contribution to the literature on FGM. The first significant contribution of this study is the qualitative empirical data from semi-structured in-depth interviews with women from FGM-performing communities and stakeholders responsible for designing and enforcing the law in England. This is to my knowledge the first time a large research study consisting of over 70 participants has been undertaken. The data gathered from the interviews aims to fill a void in the landscape of empirical research on FGM.

Second, this study is to my knowledge the first empirical study to analyse women's and stakeholders' attitudes and beliefs towards FGM and the law. The aim is to provide an analysis of women's experiences of FGM and the law and stakeholders' understandings of the practice and the barriers to enforcing the law. There have been recent changes to criminal law and FGM following the introduction of a legal duty on stakeholders¹⁶ to notify the police of FGM when they discover a girl has been cut in the course of their work¹⁷. It is therefore

¹⁶ The law names healthcare professionals, teachers and social care workers.

¹⁷ See section 5B of the Female Genital Mutilation Act 2003.

important to consider the impact of extending the boundaries of criminal law to include making individuals and organisations legally bound to uphold the rule of law.

Third, this study does not situate FGM within one theoretical framework to the exclusion of diverse theoretical positions of feminism, international human rights, cultural relativism and critical race theory. The majority of research studies situate their research in one theoretical frame. However, this thesis aims to provide an intersectional approach to understand the multiple strands of women's inequality of gender, race, culture, class, nationality and religion and how they impact upon women's experiences of the practice and the law.

Outline of Chapters

This thesis is divided into seven chapters. The first two chapters review the literature, theory, law, policy and political trajectory of FGM. The third chapter outlines the methodological approach. Chapters four, five and six set out the findings from the empirical data of this study and the final chapter concludes the thesis.

Chapter One examines law and policy and political narratives from an international and national perspective and it explores national responses to FGM in England.

Chapter Two sets out the following theoretical frameworks of feminism, international human rights, cultural relativism and critical race theory. The purpose is to contextualise FGM within current theoretical debates and provide an intersectional lens to analyse women's experiences of FGM within a context of structural inequalities of gender, race, culture, nationality and religion.

Chapter Three explains the methodology of the empirical research. I outline the aims and objectives of the methodology and the rationale for employing a qualitative research study, which involves semi-structured in-depth interviews of women and stakeholders. The chapter explores the challenges and limitations of the methodology, ethics and reflexivity.

Chapter Four is the first empirical data chapter, which highlights women's experiences of FGM and stakeholders' understandings of the practice. The chapter provides a solid foundation for understanding the core motivations for the persistence of FGM in a context in which the practice is criminalised.

Chapter Five explores women's attitudes and beliefs towards the criminalisation of FGM. The first part of the chapter addresses women's attitudes towards the law and the ways in which women have adapted the practice to avoid detection from stakeholders. The second part of the chapter highlights stakeholders' attitudes towards the law and how they believe the practice has been adapted to ensure communities avoid detection.

Chapter Six focuses on the barriers to the law deterring and eliminating FGM. The first part of the chapter shows women's attitudes and beliefs towards the barriers to the implementation of law in practice. Women's views highlight the challenges to social and cultural change through the law. The second part of the chapter draws on stakeholders' attitudes towards the barriers to the law functioning effectively. It highlights the difficulties stakeholders encounter in enforcing legislation in cases of FGM.

Conclusion is the final chapter drawing together the key themes from the thesis and suggests future research and key legal and policy changes to support women and girls and eliminate the practice.

Chapter One:

The Law, Policy and Politics of Female Genital Mutilation

“Many people are amazed that your Lordships are still discussing this horrific custom, which appalled most people in Britain when they realised it was practiced here even though by a small minority of people.”

Baroness Masham of Ilton.¹⁸

Introduction

This chapter sets out the background of legal, policy and political change in England relating to the practice of FGM. The aim is to outline the legal changes implemented to criminalise FGM and to provide an overview of the evolving political landscape. This will assist in answering the overarching research question of why FGM persists despite the criminalisation of the practice in 1985. This study analyses the law from a sociological perspective focusing on the potential of social and cultural change through the law. To my knowledge there are no studies measuring the efficacy of law in changing attitudes and beliefs towards FGM, perhaps due to the challenges of conducting reliable research given the infinite number of variables.

To engage theoretically and critically with the law, this chapter examines the background of key legislative and policy changes in international human rights law and in national law in England. While aspects of the chapter may read as a report, it is necessary to outline the legal status quo in order to answer the core research question of why FGM persists when it is a criminal offence. This chapter does not provide a critical examination of the nuances of law and policy, nor does it provide historical and international comparisons, because this thesis is not *primarily* a legal study. The purpose of this chapter is to show potential, challenges and lacunas in law and policy, which provides a foundation for the analysis of empirical data in chapters four, five and six and the conclusion in chapter seven.

The first part of the chapter explores scholars’ work on women’s experiences of legislative and political changes about FGM from an intersectional perspective of gender, race, culture, class, nationality and religion. This involves exploring theories of cultural relativism, feminist

¹⁸ UK *Hansard* debates of 1985.

legal theory and critical race. This chapter does not address the impact of legal measures upon the practice of FGM or women's experiences of FGM laws because there is no literature on this topic and the law has not been enforced¹⁹. However, the empirical chapters address why women and stakeholders believe FGM persists when the practice is criminalised. The second part of the chapter examines the international human rights framework developed to eliminate FGM. The third part of the chapter addresses national law and policy in England implemented to tackle FGM. The final part of the chapter analyses anti-FGM movements organised by survivors, political responses to such movements and consequent emerging legislative and policy responses designed to address public calls to end the practice.

Applying Intersectionality to a Legal Analysis of Female Genital Mutilation

The purpose of this section of the chapter is to set out an intersectional theoretical framework for analysing the law from the perspective of cultural relativism, critical race theory and feminism. First it is important to set out the importance of law as identified in the literature. The law, in particular the criminal law, is an important institution that maintains social control within society. It therefore requires close scrutiny. Ashworth and Zedner (2014) argue that the objective of the criminal law is “to prohibit behaviour that represents a serious wrong against an individual or against some fundamental social value or institution” (1). Lacey (2011) contends the criminal law is about “steering populations’ behaviour.” There is broad consensus amongst academics that the purpose of the criminal law is to prohibit, deter and protect. Arguably the consequences of violating the criminal law are intended to act as a deterrent. Acceptable and unacceptable behaviour as defined by the criminal law changes over time as societal norms and values evolve.

There are tensions amongst academics about what should be the subject of criminal law, particularly when criminal offences impact disproportionately on ethnic minorities (Kymlicka, Lernerstedt, & Matravers, 2014: 8). Issues regarding religious clothing, education and family law minority rights have become increasingly heated within the literature, as they raise intersectional issues of race, culture, nationality and religion. Cultural relativists contend that cultural groups should have a defence to criminal offences that seek to prohibit cultural practices that are sacred to their identity (Shweder, 2004). Gallin (1993) shows that cultural evidence has been used to justify violence against women partners in criminal courts.

¹⁹ There has not been on conviction for FGM in England.

Violence in immigrant communities is often viewed as having explanatory power (Sokoloff & Dupont, 2005). The viability of raising a cultural defence to the crime of FGM is discussed further in the literature review and in the empirical chapters.

In terms of gender, feminist legal theory places women's experiences at the forefront of legal analysis. Conaghan (2000) identifies three mainstream features of feminist legal theory, first, a women's perspective is essential to understanding the law; second, women should be placed at the centre of legal scholarship rather than embarking on a quest for neutrality and objectivity and; third, it is imperative to expose the law's implication in discrimination, domination and oppression of women with a view to bringing about social, political and legal change (363). Adopting a feminist legal approach is essential to critiquing FGM legislation and policy from a women's perspective.

Along with feminist legal scholars, this study dismisses law's historical claim to neutrality, objectivity, truth and knowledge (Lacey, 1998; Thornton, 1996). According to Smart (1995), the law is a particularly powerful discourse because of its 'objective' claim to truth, which in turn silences women who encounter the law and feminists who challenge the law (71). The feminist unpacking of the largely hidden gendered content of law has advanced our understanding of law as irretrievably 'male' – the recognition that law is gendered shows the ways in which law produces or contributes to inequality (Conaghan, 2009: 365). This raises an important question for this study, namely whether the law's hidden male perspective is one of the reasons why the law appears to have failed to have any impact upon FGM, which is an inherently gendered practice.

Feminist scholars have been divided about the centrality of law as a means of changing the position of women in society (Lacey, 1998: 8). Increasingly the law has become seen as an aid rather than an obstacle to feminist aspirations (Conaghan, 2009). Feminist legal scholar and American lawyer Catharine MacKinnon (2005) posits that law can be used to engender a radical transformation. In contrast, Smart (1989) argues that feminists cannot predict the outcome of law reform – once law is enacted, the law is in the hands of individuals and agencies far removed from the women's movement (164). There is a conflict in the assertion that on the one hand the law is an epiphenomenal effect of patriarchy and on the other hand the women's movement can use the law to dismantle patriarchy (Smart, 1995: 186). I follow MacKinnon (2005) when viewing legislative reform, recognising that it can have the power to change women's lives and position in society, whilst acknowledging the limitations of legal institutions in bringing about material change. This study intends to explore whether the law has brought about social and cultural change towards FGM.

While feminist legal theory addresses women's experiences of the law, critical race theory is fundamental to exploring race inequalities and the impact of intersecting patterns of discrimination upon ethnic minority women's experience of the law. The presentation of law in scholarly work as neutral and objective means the domination of sexism and racism through the law are often ignored (Nash, 2008). Critical race theorist Crenshaw (1991) argues ethnic minority women's experience of the law is often shaped by other dimensions of their identities, such as gender, race and class (1242). She explains that there are cultural and class complications to the enforcement of law when immigrant women in particular have limited access to resources, language barriers present as structural problems and cultural barriers discourage them from reporting or escaping violent situations (Crenshaw, 1991: 1248). Economic and social barriers preventing ethnic minority women from seeking the enforcement of the law mean they are less likely to have their cases pursued in the criminal law arena (Crenshaw, 1991; Sokoloff & Dupont, 2005).

Feminists and critical race scholars have explored the politics of the body and contributed to an analysis of the process whereby ethnic minority women's bodies are sexualised, objectified, regulated and violated by institutions of patriarchal society, which includes the legal system (Bridgeman & Mills, 1995). Scholars have shown that women's bodies have emerged as a site of struggle and a focus of legal fascination and at the same time the legal system has played a role in silencing women and rendering their needs, if not their bodies, invisible, for example in cases of abortion, prostitution and pornography (Bridgeman & Mills, 1995). Ethnic minority women's experiences of the legal system are rarely addressed in the literature and yet FGM law is gender-specific. This thesis is concerned with how the law attempts to prevent FGM, women's experiences of criminalisation and stakeholders' response to FGM and the law. Exploring these issues will assist in answering the overarching research question of why FGM persists when the practice has been criminalised in England.

Development of an International Human Rights Framework Addressing Female Genital Mutilation

This part of the chapter explores the events that led up to FGM being incorporated within an international human rights framework. Despite defining FGM as a human rights violation, the practice still persists. It is therefore necessary to examine the attempts taken by the international community to eliminate FGM. It took decades for the international community to take action against the practice. Prior to the 1970s, FGM was considered a legitimate

cultural practice. The start of the UN involvement was in 1958, when the UN Economic and Social Council asked the WHO to examine the practice and its plans for eradication, but the WHO declined in 1959 “because it regarded the matter as a cultural issue” (Brennan, 1988; Lionnet, 2005: 97). The UN Economic and Social Council asked the WHO to research FGM again in 1961, but the WHO refused. Feminists criticised the UN and international organisations for marginalising the issue of FGM for almost two decades because of cultural relativist concerns (Brennan, 1988: 377-378).

According to Toubia (1995b), NGOs and Western and African women continued to make public statements and release reports, which exposed the issue and removed a shroud of silence. Eventually the WHO organised a conference on FGM in 1979 and the WHO and UNICEF organised a meeting about FGM in 1980. This led to UNICEF and the WHO assisting in establishing the Inter-African Committee on Traditional Practices (Gunning, 1999: 678). A sizeable opposition movement to FGM including both Africans and non-Africans developed by the early 1980s (Gunning, 1999: 679). In the 1980s, members of the opposition movement eventually worked out an agreement which called for non-Africans to refrain from criticism, but to assist with technical and financial assistance (Brennan, 1988: 379). It was thought that non-African’s intervention into FGM was contributing to African women resisting eradication efforts of international organisations. FGM was firmly on the international agenda by the mid-1990s. The Inter-African Committee successfully lobbied for the inclusion of a ban of FGM in the draft Protocol to the African Charter on the Rights and Welfare of the Child in 1990 (Wheeler, 2003).

Pressure from the international community mounted on nations to introduce national laws prohibiting FGM, which resulted in the UK enacting the Prohibition of Female Circumcision Act 1985. While FGM is recognised as a harmful practice in England, the introduction of various international treaties reaffirmed the status of FGM as a violation of the rights of women and girls (World Health Organisation, 2008: 8). The UK is formally committed to a range of international human rights instruments including the European Convention on Human Rights (ECHR)²⁰, which compel the state to take proactive measures to eliminate FGM. Human rights are codified in several international and regional treaties that are relevant

²⁰ The ECHR is an international treaty designed to protect fundamental freedoms in Europe with the enactment of convention articles and protocols. The following articles of the ECHR relate to FGM: Article 1 binds signatory states to secure the rights of the ECHR within their jurisdiction; Article 2 protects the right of a person to life; Article 3 prohibits torture and inhuman or degrading treatment; Article 8 ensures a person’s right to private and family life.

to the UK. The legal regime is complemented by a series of political consensus documents, such as those from UN world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfilment (World Health Organisation, 2008: 8).

International treaties	UK Signature	UK Ratification
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	15 March 1985	8 December 1988
Covenant on Civil and Political Rights	16 September 1968	20 May 1976
Covenant on Economic, Social and Cultural Rights	16 September 1968	20 May 1976
Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)	22 July 1981	7 April 1986
Convention on the Rights of the Child (CRC)	19 April 1990	16 December 1991
Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees	28 July 1951	11 March 1954
Regional treaties	UK Signature	UK Ratification
European Convention for the Protection of Human Rights and Fundamental Freedoms	4 November 1950	8 March 1951
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	26 November 1987	24 June 1988
Consensus documents the UK supported		
Beijing Declaration and Platform for Action of the Fourth World Conference on Women		
General Assembly Declaration on the Elimination of Violence against Women		
Programme of Action of the International Conference on Population and Development (ICPD)		
UNESCO Universal Declaration on Cultural Diversity		
United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on Ending Female Genital Mutilation. E/CN.6/2007/L.3/Rev.1.		

By ratifying the Convention on the Elimination of all Forms of Discrimination against Women 1979 (CEDAW), the UK committed itself to *eliminating* discrimination against women and to intervening to modify social and cultural patterns of behaviour that result in discrimination against women (Article 5). FGM unambiguously constitutes discrimination against young women and girls (Bar Human Rights Committee, 2014: 7). By virtue of the Convention on the Rights of the Child 1989 (CRC), the UK has *positive* obligations in international law to *ensure* that children are not subjected to cruel, inhuman or degrading treatment (Article 37) (Bar Human Rights Committee, 2014: 7). FGM constitutes an irreparable violation of the child's bodily integrity and endangers the child's physical and

psychological health (Bar Human Rights Committee, 2014: 7). In addition, the UK has a legal duty pursuant to CRC 1989 to ensure that mechanisms are adequately resourced to the maximum extent of resources available (Article 4) (Bar Human Rights Committee, 2014: 8). In a UN General Resolution in 2007, the UN emphasised that custom, tradition or religious beliefs cannot be used as excuses for avoiding the obligation to eliminate violence against women and girls²¹.

Typically, the implementation of a treaty is overseen by a UN Committee. Many of the UN human rights treaty committees have addressed FGM in their concluding observations on how states are meeting their treaty obligations (World Health Organisation, 2008: 8). For instance, the Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee have condemned FGM and recommended measures to combat it, including the criminalisation of the practice by national states (World Health Organisation, 2008: 8).

These legal obligations, among others, place a requirement on national states to respond to FGM in an effective way. Passing legislation that is ineffectively implemented is not enough. Legislation must be combined with other measures such as mandatory training for frontline stakeholders specifically in FGM. Indeed, the Bar Human Rights Committee (2014) report on FGM²² found that “the UK has been in breach of its international law obligations to protect

²¹ See: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/61/143&Lang=E [Accessed 02.05.2017]

²² As a member of the Bar Human Rights Committee (BHRC) of England and Wales working group on FGM, I along with other barristers and academics specialising in international human rights assisted in compiling written evidence for The House of Commons, Home Affairs Committee on FGM. The report advised that the UK is in breach of its international legal obligations in failing to protect vulnerable girls from FGM. The Committee relied heavily on the report in making its final recommendations. The government adopted two of our key recommendations: the introduction of FGM Protection Orders and a National FGM Centre. In addition, I worked with the BHRC to draft written evidence, which was submitted to the Office of the United Nations High Commissioner for Human Rights, in preparation for the report for the March 2015 session of the Human Rights theme, *‘Towards a better investment in the rights of the child’*. The report proposes a range of measures designed to protect children from FGM internationally. See <http://www.ohchr.org/Documents/Issues/Children/TowardsInvestment/BarHumanRightsCommittee.pdf> [accessed 23.04.2015]. I have addressed the relevance of my background and the

young women and girls from mutilation,” which is a “serious breach of the state’s duty of care” (Bar Human Rights Committee, 2014: 10). The UK lacked a sufficiently tailored or a targeted legal power to assist in intervening in cases where FGM is suspected. The law alone was not sufficient to eliminate the practice (Bar Human Rights Committee, 2014: 10). Other initiatives were proposed, including funding for community and grass-roots-led groups working with women affected by FGM and mandatory training for frontline stakeholders. Other initiatives aside from law and policy are explored further throughout the thesis.

Stereotypes and Racist Representations of Marginalised Women in Politics and Law

To answer the research question of why FGM persists in England when the practice is a criminal offence, it is necessary to examine the impetus for introducing criminal legislation and FGM-performing communities’ response to the law. Increasing international pressure to criminalise FGM was one of the pivotal reasons for the introduction of specific criminal legislation on FGM. Another impetus for the legislation were emerging concerns that FGM was being performed in England by migrants who moved to England from the Horn of Africa in the 1970s and 1980s and continued to practice FGM. FGM became a matter of public concern in the early 1980s, after a Malian child died from the practice in England (Dorkenoo, 1994: 142) and there were reports of FGM being carried out in private health clinics and on the medical black market in the UK (Dustin & Phillips, 2008: 414). FORWARD, an anti-FGM NGO was proactive in highlighting the prevalence of the practice. In the early 1980s, NGOs and a few committed politicians launched a legislative campaign aiming to pass the first legislation prohibiting FGM (Kwateng-Kluytse, 2005: 65). This prompted a series of legislative and policy changes in the 1980s (Rogers, 2013: 71).

The purpose of the initial legislation in 1985 was to send a clear message that FGM will not be tolerated, to show universal condemnation of the practice and to clarify the law (Rogers, 2013: 71). Arguably, FGM was already a criminal offence under other offences, for example actual bodily harm or grievous bodily harm. As Baroness Trumpton in the Houses of Parliament stated in 1985, “the whole purpose of the Bill is to make the law crystal clear.”²³ Political debates gave politicians the opportunity to publicly condemn the practice as barbaric

impact of my background upon the thesis, as well as reflexivity issues in the introduction of the thesis.

²³ UK Hansard, Prohibition of Female Circumcision Bill, vol. 465 cc. 207-24, 1985.

and send a clear message to the public that FGM will not be tolerated. Lord Glenarthur described the practice in the 1980s as “not compatible with the culture of the country” and “thoroughly repugnant to our way of life” (HL Debs, 447, col 86). FGM legislation legitimised the role of the British state in enforcing British values and norms upon migrant communities.

Academic Rogers (2013) analysed parliamentary debates about FGM and argued that hyperbole language and images of tortured girls were convened to legitimise the production of law (4). The stories highlighted during debates about the criminalisation of FGM were infused with notions of loss of girls and women’s freedom and loss of their sexuality (Rogers, 2013: 4). Political debates created a universal, singular and monolithic portrayal of the practice based on a cruel image of a girl being held down and cut (Rogers, 2013). As Baroness Mashom of Ilton stated in the House of Lords during a debate on FGM recorded in UK *Hansard* in 1985:

“My Lords, it has been said over and over again that all noble Lords who have taken part in these states of the Prohibition of Female Circumcision Bill are against this cruel and mutilating practice and this has also been stressed by the noble Lord, Lord Hatch of Lusby, tonight. Many people are amazed that your Lordships are still discussing this horrific custom, which appalled most people in Britain when they realized it was practiced here even though by a small minority of people.”

The horrific single image of the torturous practice of FGM is invoked time and time again during political debates. FGM is described as a ‘cruel and mutilating practice’ and a ‘horrific custom,’ which justified the need for law. The intersection of racist, patriarchal and static representations of African women are often used in legislative efforts to criminalise FGM (Rogers, 2013: 24, 26). Rogers (2013) concluded that the instigation of anti-FGM law suffered from an urgency that accompanied demands to prevent child abuse, which was at the expense of consultation with communities who would be affected by the law (7). Stereotypical perceptions of black women as aggressive and immune to the effects of violence have prevented black women from receiving equal treatment in the criminal justice system (Ammons, 1995; Sokoloff & Dupont, 2005: 53). Racist narratives accompanying legislation may have the unintended consequence of ethnic minority women feeling disempowered and reluctant to use the police to deal with cases of FGM (Sokoloff & Dupont, 2005)²⁴.

²⁴ This is explored further in the empirical chapters

It is noteworthy that a specific criminal offence was introduced to criminalise FGM while there is no legislation criminalising other cultural and traditional practices. For instance, there is evidence that South Asian communities practice discrimination on grounds of caste in the UK and yet there is no legislation prohibiting this despite efforts to introduce laws (Waughray, 2009). The core reason for the focus on FGM, forced marriage, honour killings and women's Islamic dress to the exclusion of other cultural practices is that Government public policy and legal judgment has focused on violence against women and girls within Muslim communities (Dustin & Phillips, 2008). Concerns about cultural practices of violence against women and girls must be situated within British discourse on multiculturalism and women's rights and the development of legislation that enforces British values and norms upon 'other' cultures and communities.

Legislative Initiative: The Prohibition of Female Circumcision Act 1985

Under the 1985 Act (and now Female Genital Mutilation Act 2003), a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris.²⁵ There are exceptions to the offence when it is necessary operations performed by a registered medical practitioner on physical and mental health grounds²⁶ but no account shall be taken of the effect of any belief of custom or ritual.²⁷ A further exception is when a registered medical practitioner performs an operation on a woman who is at any stage of labour or has just given birth for purposes connected with labour or birth²⁸.

The 1985 Act and later the 2003 Act, permitted a legal double standard that has been the subject of extensive scholarly debate (Avalos, 2015; Chambers, 2008; Dustin, 2010; Gunning, 1991; Sheldon & Wilkinson, 1998). Concerns emerged during political debates about the 1985 Act that the wording would criminalise cases where girls have anxieties about the shape or size of their healthy genitalia and their distress can only be alleviated through surgery (Dustin & Phillips, 2008). The medical colleges mobilised to block legislation that would

²⁵ Section 1(1)(a) of the 1985 Act and Section 1(1) of the 2003 Act.

²⁶ Section 2(1)(a) of the 1985 Act and Section 1(2)(1) of the 2003 Act.

²⁷ Section 2(2) of the 1985 Act and Section 1(5) of the 2003 Act.

²⁸ Section 2(1)(b) of the 1985 Act and Section 1(2)(b) of the 2003 Act.

criminalise these procedures and the government introduced an amendment to allow for genital surgery ‘where necessary for physical or mental health,’ but prevented any account being taken on ‘any belief... that the operation is required as a matter of custom or ritual’ (Dustin & Phillips, 2008: 414). The law allowed a girl or woman to conform to Western norms of how one’s body (or genitalia) should look, but it prevented conformity to minority cultural norms (Dustin & Phillips, 2008: 414).

The 1985 Act and then the 2003 Act criminalises FGM when performed on girls and women, there is no age distinction and consent is no defence. It is harder to justify the ban on FGM for adult women when female genital cosmetic surgery is permitted without any opposition. This appears to be an inconsistency that can only be explained by presumptions about the capacity of ethnic minority women to consent. Women are believed to have the capacity to consent if they come from the West, while the consent of ethnic minority women is denied. If FGM were banned because of the harm to women, scholars Dustin and Phillips (2008) and Sheldon and Wilkinson (1998) contend that we might expect the law to ban more physically invasive forms of FGM for adult women, but permit less invasive forms of FGM for adults. The key distinction according to UK law is that cosmetic surgery reflects ‘choice’ defined by sexual freedom outside of cultural pressures while FGM reflects cultural coercion and the absence of agency through the lack of a clitoris (Rogers, 2013). The law could be guilty of infantilising ethnic minority women, as they are deemed incapable of consenting to practices on their genitalia. This arbitrary differentiation of FGM and FGCS is subject to extensive scholarly criticism as outlined in the literature review. The empirical chapters explore ethnic minority women’s experiences of racial and gender-based discrimination through the law.

Legal Advances and a New Criminal Law: The Female Genital Mutilation Act 2003

FGM was resurrected as a public concern in the 1990s following the failure of the state to secure a prosecution or conviction for FGM since the introduction of legislation in 1985. The Anti-FGM NGO FORWARD continued their campaign work, putting pressure on the government to make FGM a political priority. Political pressure mounted following a report produced by the All-Party Parliamentary Group on Population Development and Reproductive Health in 2000 that argued for legislative and policy change in a bid to tighten the law and prevent loopholes. As a result the Female Genital Mutilation Act 2003 was introduced and it replaced the 1985 Act.

The 2003 Act changed the wording of the Act from ‘circumcision’ to ‘mutilation’ to achieve clarity and send a strong message (Rogers, 2013: 73). The Act also made it a criminal offence to perform FGM in the UK or abroad²⁹, to assist a girl to mutilate her own genitalia in the UK or abroad³⁰ and to assist a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident³¹. The Act also increased the maximum sentence to 14 years imprisonment³². There was no meaningful debate about the consent of adult women to FGM or the ‘necessary for mental and physical health’ exemption, which remained in place. Dustin and Phillips (2008) write that the changes still do not differentiate between ‘cultural’ and ‘cosmetic’ cases (415).

Political Activism that Places Women on the Sidelines of Power

Survivors of FGM and anti-FGM NGOs³³ mobilised in 2012 to start a high-profile movement in England to put FGM on the political agenda. Women challenged the taboo of FGM by sharing their stories in public – evoking an emotional response. For the first time, the faces of young ethnic minority women were published on the front page of mainstream newspapers, as they described their story of FGM. Newspapers the Guardian³⁴ and the London Evening

²⁹ Section 1 of the 2003 Act.

³⁰ Section 2 of the 2003 Act.

³¹ Section 3 of the 2003 Act.

³² Section 5 of the 2003 Act.

³³ The late Efua Dorkenoo was a renowned anti-FGM activist. She had dedicated much of her life to campaigning against the practice. Survivors Leyla Hussein and Nimco Ali, founders of the NGO Daughters of Eve, are arguably two of most high profile anti-FGM activists. They gained public notoriety in 2012 after sharing their own stories and demanding legal and policy change in England <http://www.dofeve.org/leyla-hussein.html> [accessed 7.1.2016]. Leyla Hussein presented BAFTA nominated Channel 4 documentary “the Cruel Cut,” about FGM in the UK <http://leylahussein.com/the-cruel-cut/> [Accessed 07.01.2017].

³⁴ The Guardian Global Media Campaign to end FGM ran from May 2014 to September 2015 and its budget was \$1 million. The focus of the campaign was initially to accelerate the end of FGM in the UK and it later expanded its focus to other countries. The aim is to ensure FGM remains high on the social and political agenda <https://www.human-dignity-foundation.org/wp-content/uploads/2016/06/Guardian-EndFGM-Final.pdf> [Accessed 07.01.2017].

Standard³⁵ launched anti-FGM media campaigns in 2014 raising public awareness of the practice. A sizeable opposition movement developed. Responding to a public outcry that there had still not been one conviction for FGM, the House of Commons Home Affairs Committee launched an inquiry into FGM in 2014. The inquiry examined why FGM continued to persist in England and what action is needed to protect girls at risk of FGM. Witnesses who had undergone FGM and stakeholders who worked with those affected by FGM gave evidence at the inquiry. The Committee published a report on 3 July 2014. It recommended a national action plan, which would involve “strengthening the law on FGM, principally to ensure the safeguarding of at-risk girls, but also to increase the likelihood of achieving successful prosecutions”.

The House of Commons Home Affairs Committee inquiry into FGM made comparisons between the approaches adopted in the UK and in France throughout their report. France is often held up as a leading example, having achieved more than 40 prosecutions since 1979 resulting in the conviction of over 100 parents and cutters (Rahman & Toubia, 2000). In France there is no specific legislation criminalising FGM, instead perpetrators are prosecuted for crimes such as bodily harm and child cruelty. There is no need to establish who performed FGM, instead parents can be prosecuted for failing to protect children from FGM. Children up to the age of six have regular medical check-ups. Girls at risk of FGM undergo medical examinations annually and when they return from abroad. The system is largely mandatory, as social security benefits are dependent upon participation in health screening. If FGM is identified, stakeholders are required to report cases to the police, failing to do so could result in prosecution. There appears to be no political will to adopt a similar system in the UK. The committee did not recommend introducing comparable measures.

During the House of Commons Home Affairs Committee Inquiry on 21 March 2014, the Director of Public Prosecutions, Alison Saunders announced the first (and only) prosecution for FGM only hours after she gave oral evidence before the Inquiry³⁶. A British-Somali

³⁵ The Evening Standard commenced a campaign to end FGM in Africa on 9 October 2014, which involved spreading stories of change, supporting media campaigns and organising events, as well as working on programmes abroad <http://www.standard.co.uk/news/london/new-campaign-to-end-female-genital-mutilation-in-africa-9784134.html> [Accessed 07.01.2017].

³⁶

http://www.cps.gov.uk/news/latest_news/first_prosecutions_for_female_genital_mutilation/ [Accessed 16.02.2017]. See CPS announcement of the first prosecution for FGM.

doctor, Dr Dhanuson Dharmasena of Whittington hospital, North London, was charged with re-infibulating³⁷ a Somali-born British patient after she gave birth. Hasan Mohamed, the woman's husband, was charged with intentionally encouraging an offence of FGM and aiding, abetting, counselling or procuring Dr Dharmasena to commit an offence. The case was unusual, as the complainant³⁸ gave evidence on behalf of the defence thereby supporting the defendants. The case was a media spectacle with daily reports about the trial. On 4 February 2015 the jury found the defendants not guilty after only 30 minutes of deliberation. The Judge criticised the Whittington hospital for failing to have appropriate support structures in place for medical practitioners supporting women who had undergone FGM.

The Government responded to growing public, political and media pressure³⁹ by hosting the first Girl Summit on 22 July 2014, co-hosted by UNICEF⁴⁰. The Summit aimed at mobilising domestic and international efforts to end FGM and child, early and forced marriage within a generation. The government used the summit as an opportunity to make legislative and policy announcements. It pledged to establish a dedicated anti-FGM Unit, which became the National FGM Centre⁴¹, to provide outreach work, resources for frontline staff and £3 million

³⁷ Women who request to be reinfibulated by health stakeholders are denied with the explanation that it contravenes anti-FGM laws (Rogers, 2013: 37). See Rogers (2013) for a critique of criminalising reinfibulation and denying women the right to choose to be reinfibulated.

³⁸ The term 'complainants' is used by the criminal justice system, as it is unclear whether they have been subject to wrongdoing until a verdict has been reached. However, in the FGM case the woman was not technically the complainant, as she did not make a complaint about FGM or support the prosecution. A midwife working with the doctor referred the case to the police.

³⁹ Young anti-FGM campaigner Muna Hassan, a member of UK anti-FGM campaign group *Integrate*, told the then Prime Minister David Cameron to "grow a pair" on Newsnight in 2014 as she encouraged the government to make FGM a political priority. Hassan along with five other members of *Integrate* took a *Guardian* supported petition with over 230,000 signatures to the then Secretary of State for Education, Michael Gove MP, requesting him to ensure schools teach about the risks of FGM and he agreed to email information about FGM to schools. <https://www.theguardian.com/world/2014/dec/14/muna-hassan-faces-of-2014-one-of-us-mentioned-vaginas-and-michael-gove-went-really-red> [Accessed 7.1.2017].

⁴⁰ For more information see <https://www.gov.uk/government/topical-events/girl-summit-2014> [Accessed 07.01.2017].

⁴¹ The centre is run by NGO Barnardos with government funding. There were concerns in March 2017 that the centre may have to close due to the cessation of funding from the

funding for national FGM prevention programmes⁴². Internationally, the UK launched a £35 million programme to tackle FGM globally⁴³. Subsequently, the government launched the ‘Girl Generation’ in October 2014 supported by the Department for International Development, funding grassroots initiatives globally designed to eliminate FGM⁴⁴.

Calling for Further Legislation in the Fight Against Female Genital Mutilation: The Serious Crime Act 2015

The government’s next step was to introduce further legislative change⁴⁵. On 9 December 2014, the Government responded to the House of Commons Home Affairs Committee report on FGM and proposed to introduce five legislative changes. However, the Government did not adopt the other proposed non-legislative changes such as mandatory training for front-line stakeholders, increased funding for grassroots NGOs working with women and girls and introducing FGM as an educational requirement within schools. Instead, the Government chose to enact further legislation thereby focusing on punitive sanctions. The Serious Crime Act 2015 was enacted, which gave rise to amendments to the Female Genital Mutilation Act 2003.

1. Offence of Female Genital Mutilation: Extra-Territorial Acts

The Female Genital Mutilation Act 2003 was originally concerned with acts done by UK nationals or permanent UK residents to girls or women who are UK nationals or permanent UK residents. Perpetrators and victims who were merely habitually resident in the UK were not covered by the legislation. The Bar Human Rights Committee (2014) noted in its report on FGM that “the UK’s legal obligations extend to all children within its jurisdictions –

government. In July 2017 it was announced the government had committed to funding the centre.

⁴² See https://www.unicef.org/protection/files/6.1057_DFID_AR_Girl_Summit_Final_web_20072015.pdf [Accessed 07.01.2017].

⁴³ *Ibid.*

⁴⁴ For more information see <https://www.gov.uk/government/topical-events/girl-summit-2014> [Accessed 07.01.2017].

⁴⁵ For a discussion and critique of the five key legislative changes see Ekaney QC and Proudman (2015).

therefore UK organisers of such mutilations should face prosecution, irrespective of the child's status" (3). The Serious Crime Act amended sections 1 to 3 of the 2003 Act to apply to habitual residents. There are a range of factors to consider when determining if a person is habitually resident in the UK, including the length of presence in UK, reason for visiting the UK, intended duration of stay and their ties to the UK. The Act does not, however, protect those who are temporarily based in the UK. No provision is made for instance for a woman who travels to the UK for a short period, visits a National Health Service (NHS) doctor who discovers that the woman has been subjected to FGM and intends that her daughter(s) should also be subjected to the procedure and then returns to her country of origin a few days later.

2. Anonymity for Victims of Female Genital Mutilation

The Act now provides lifetime injunctions prohibiting the publication of any matter that could lead the public to identify the alleged victim of an offence under the Act⁴⁶. This measure was introduced to encourage the reporting of FGM offences without fear of identification.

3. Offence of Failing to Protect a Girl from Risk of Female Genital Mutilation

A person is liable for an offence if they are responsible for a girl under the age of 16 when FGM is performed. The term 'responsible' covers two classes of person. First, a person who has 'parental responsibility' for the girl and has 'frequent contact' with her and, second, any adult who has assumed responsibility for caring for the girl in the manner of a parent, for example, grandparents who might be caring for the girl during the school holidays. There are two possible defences. The first is that the defendant did not think that there was a significant risk of the girl being subjected to FGM and could not reasonably have been expected to be aware that there was any such risk. The second defence is that the defendant took reasonable steps to protect the girl from being the victim of FGM. The wide drafting of the defences could prove a challenge to implementation. Christou and Fowles (2015) argue the offence recognises that the continuation of FGM is based on parental choices (345, 350). The offence also sends a clear message to parents that they could be prosecuted if they perform FGM. Parents may use the law as an advocacy tool to argue for the elimination of FGM in a context

⁴⁶ The power to waive the restrictions is limited to the circumstances necessary to allow a court to ensure that a defendant receives a fair trial (Article 6 ECHR) and to safeguard freedom of expression (Article 10 ECHR).

of community and familial pressure. Christou and Fowles (2015) contend the offence does not disproportionately target women; instead it can apply to any person. However, this fails to recognise that ethnic minority women are largely responsible for organising and carrying out FGM and therefore they will be disproportionately subject to criminal law sanctions.

4. *Female Genital Mutilation Protection Orders*^[SEP]

The introduction of FGM Protection Orders⁴⁷ was a key recommendation of the Bar Human Rights Committee (2014). An order can be made to protect either a girl or woman at risk of FGM without immediate criminal sanctions for parents⁴⁸. FGM protection orders are modelled on forced marriage protection orders introduced by the Forced Marriage (Civil Protection) Act 2007. The terms of such an order can be broad and flexible and enable the court to include whatever terms it considers necessary and appropriate to protect the girl. These include, for example, provisions requiring a person to surrender his or her passport. Breach of the order is a criminal offence.

The first reported case is *Re E (Children) (Female Genital Mutilation Protection Orders)* [2015] EWHC 2275 (Fam). Mrs Justice Hogg sitting in the Family Division of the Royal Courts of Justice on 22 July 2015 ordered an FGM Protection Order without notice to the father, after a Nigerian mother applied for protection of her three daughters then aged 12, 9 and 6. The mother feared that the father, who was resident in Nigeria, could subject her daughters to FGM. On 24 July 2015, Mr Justice Holman, relying on information in the mother's statement of risk, renewed the FGM Protection Order without notice to the father, who was in Nigeria. Mr Justice Holman allowed a prohibition in the order from the father coming within 100 meters of the mother's home and the children's school. However, the Judge cautioned that courts should not introduce far-reaching provisions in orders (paragraph

⁴⁷ There were 28 applications and 18 orders made for FGMPOs in July to September 2015, following their introduction on 17 July 2015. Available at: http://www.familylaw.co.uk/news_and_comment/fgmpo-figures-published-for-first-time-in-family-court-statistics#.Vvp5AMdBDdk [Accessed 02.05.2017].

⁴⁸ Available at: http://www.familylaw.co.uk/news_and_comment/re-e-children-female-genital-mutilation-protection-orders-2015-ewhc-2275-fam#.Vvp52MdBDdk [Accessed 17.01.2017].

27 of the judgment). At a further hearing before Mr Justice MacDonald⁴⁹ it transpired that the mother in the case had “fundamentally and dishonestly misrepresented the true position” as it turned out the case was an “immigration scam” to obtain refugee status on the basis of a well-founded fear of persecution of FGM in Nigeria. The father had travelled from Nigeria to England to inform the court of the true position, at which point the Judge determined the children should return to his care.

5. Duty to Notify Police of Female Genital Mutilation

A new criminal offence places a duty on persons who work in a ‘regulated profession’ in England and Wales, namely healthcare stakeholders, teachers and social care workers, to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under 18. The term ‘discover’ would refer to circumstances where the girl discloses to the stakeholder that she has been subject to FGM, or where the stakeholder observes the physical signs of FGM. The section does not apply to girls or women who might be at risk of FGM or cases where stakeholders discover that a woman who is 18 or over has been subjected to FGM.

This provision was the subject of a government consultation process in 2014 and many professionals objected to the proposals⁵⁰. Further research is required to ascertain whether professionals are reporting cases to the police and whether this information has been useful intelligence for the police. A Freedom of Information Act request in 2016⁵¹ asked how many cases of FGM had been reported to the Metropolitan Police Service (MPS) under the new mandatory reporting offence introduced on 31 October 2015? The answer was as follows, since 31/10/2015, there have been 31 reports to the MPS of cases of FGM of children under 18 from the following professionals 26 from Health (eight from GP's), one from Children's Social Care, one from the Dentist, two from Education and one from Nursery. The information shows that medical practitioners are the most likely professional group to come into contact with FGM-performing communities. A further Freedom of Information Act

⁴⁹ The case was reported, *CE v NE* [2016] EWHC 1052 (Fam), [http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Fam/2016/1052.html&query=\(CE\)+AND+\(v\)+AND+\(NE\)+AND+\(\[2016\]\)+AND+\(EWHC\)+AND+\(1052\)+AND+\(\(Fam\)\)](http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Fam/2016/1052.html&query=(CE)+AND+(v)+AND+(NE)+AND+([2016])+AND+(EWHC)+AND+(1052)+AND+((Fam))) [accessed 17.01.2017].

⁵⁰ For more recent objections see the British Medical Journal rapid response section of the website for medical practitioner's attitudes towards the reform: <http://www.bmj.com/content/350/bmj.h1467/rapid-responses> [accessed 16.08.2017]

⁵¹ An anonymous organisation sought the request and they relayed the information to me.

request⁵² in 2016 shows that since April 2009 there have been over 450 referrals to the MPS including 29 in 2012, 74 in 2013, 114 in 2014, 174 in 2015, 96 up to April 2016.

The obligation of public sector stakeholders to enforce the criminal law highlights the changing role of stakeholders as they are entrusted with maintaining law and order (Garland, 2001). Arguably, there has been an overreliance on law enforcement to deal with social problems of ethnic minority communities, which has led to consequences of increased surveillance, removal of children by the state and prosecution (Sokoloff & Dupont, 2005: 55). This could create tensions for immigrant women who need the state's protection from abuse, while it is a fact that state intervention increases their vulnerability (Sokoloff & Dupont, 2005: 55).

The British Association of Social British Association of Social Workers (11 February 2015) released a statement in response to the consultation warning "against blurring the boundaries between social work and other agencies such as the police and health." The offence shows the extension of the boundaries of the criminal law, as stakeholders outside of the criminal justice system are responsible for implementing the law (Ashworth & Zedner, 2014). One reason for this might be that ethnic minority women are seeking support from stakeholders outside of the law (Sokoloff & Dupont, 2005: 55).

Amasanti, Imcha, and Momoh (2016) disagree about the introduction of this offence, as they are concerned that it will drive the practice underground. Women will be less inclined to seek out support from stakeholders for fear of criminal sanctions. Any legal action could result in the 'double victimisation' of the girl, as a victim and a subject within the criminal system, rather than providing her with the support she requires (Amasanti et al., 2016: 1). Medical practitioners Creighton, Dear, de Campos, Williams, and Hodes (2016) argued that stakeholders require training in FGM if they are under a duty to report it⁵³.

⁵² See https://beta.met.police.uk/globalassets/foi-media/disclosure_2017/february_2017/information-rights-unit---prosecutions-brought-against-the-perpetrators-of-female-genital-mutilation-in-the-last-five-years [accessed 27.08.2017]

⁵³ The President of the Family Division, Sir James Munby in the FGM case of *B and G (Children) No.2* [EWFC] 3 stated that it was impossible to rely on medical evidence presented to determine if a child had been cut. At present there is no appropriate training available to assist medical practitioners to support women and girls at risk of FGM.

This new legal provision could be deficient in a number of respects. First, there appears to be a contradiction in legislation in that FGM is a criminal offence according to the 2003 Act for adults and minors and consent is not a defence and yet, stakeholders are under no duty to report cases of adults who have undergone FGM. Second, vulnerable women of at least 18 years of age who are at risk of FGM might not receive appropriate support because stakeholders have no duty to report cases involving adult women to the police. Third, if there was a duty to notify police of FGM even when the woman is an adult, this could lead to a conviction of ‘failing to protect a girl from risk of FGM’. For example, if a healthcare stakeholder discovers that a UK-born woman of 18 years or more has been subjected to FGM, her parents could be guilty of an offence of failing to protect her from FGM. However, under the new section 5B offence, a stakeholder has no duty to report the offence, thus leading to no prosecution.

Developments in Female Genital Mutilation Family Law Jurisprudence

While the focus of this thesis is criminal law, it is important to consider jurisprudence in family law in the context of FGM, as participants in the empirical chapters occasionally refer to family law remedies. Family law raises important questions about whether FGM should be conceptualised as ‘child abuse.’ When there are concerns about FGM, two specific family law remedies are usually invoked. First, FGM Protection Orders (see discussion above). Second, local authorities could intervene in cases where there is risk of FGM or FGM has been performed on children and issue care proceedings within the family law jurisdiction in order to remove children from the family and often place them in state care. I shall focus on care proceedings in this section. The legal test for care proceedings can be found within section 31 of the Children Act 1989:

- (2) A court may only make a care order or supervision order if it is satisfied—*
- (a) that the child concerned is suffering, or is likely to suffer, significant harm; and*
 - (b) that the harm, or likelihood of harm, is attributable to—*
 - (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or*
 - (ii) the child’s being beyond parental control.*

There has been one reported case of FGM within care proceedings, which assists in interpreting statute law in the context of FGM, *B and G (Children) No.2* [EWFC] 3⁵⁴. The issue in the case was whether a girl under the age of three had been subjected to type IV FGM. The President of the Family Division, Sir James Munby found that all types of FGM including type IV constitute “significant harm” within the meaning of section 31 of the Children Act 1989. The President reiterated at paragraph 68 that “any form of FGM constitutes “significant harm” within the meaning of sections 31 and 100”. He cited Baroness Hale of Richmond in *Re B (Care Proceedings: Appeal)* [2013] UKSC 33, [2013] 2 FLR 1075, paragraph 185, “that any form of FGM, including FGM WHO Type IV, amounts to ‘significant harm’” (paragraph 67 of the judgment). He then went on to draw parallels between FGM and forced marriage as gross abuses of human rights that dehumanise people (paragraph 57 of the judgment).

The President distinguished FGM from male circumcision for the purposes of section 31 of the Children Act 1989. The President found that FGM and male circumcision both involve ‘significant harm’ pursuant to section 31(2)(a). However, the clear distinction between the two practices is with respect to ‘reasonable parenting’ in accordance with section 31(2)(b)(i). FGM can never be a feature of reasonable parenting, whereas society and the law treat male circumcision as a form of reasonable parenting. This raises a series of questions about the legitimacy of invoking care proceedings for type IV FGM, which is as harmful as male circumcision, while male circumcision is permitted by society because of religion and convention. The same arguments could be used to justify type IV FGM.

Three experts were instructed in the case to give evidence as to whether the girl had been cut. On balance, the experts were unable to establish whether the girl had been subjected to FGM. The case shows the acute difficulties of locating medical stakeholders who are trained to deal with cases of FGM. Although FGM was not found to have been performed in this case, the President added, “local authorities and judges are probably well advised not to jump too readily to the conclusion that proven FGM should lead to adoption” (paragraph 77 of the judgment). As Coker (2001) cautioned, the unnecessary removal of children by the state from ethnic minority women acts as a barrier to women seeking support from law enforcement. The development of jurisprudence in family law remains at a slow pace due to few FGM cases reaching the family court arena.

⁵⁴ For a summary of the case, see C. Proudman (2015).

Structural Barriers to Women Accessing the Criminal Justice System and Barriers Preventing Stakeholders from Enforcing the Law

While the law might appear simple to enforce, there are complications that apply to ethnic minority communities that make it difficult in practice. Applying an intersectional lens, ethnic minority women are likely to experience barriers linked to gender and race, which prevent access to the criminal justice system. There are a number of reasons that there has not been one conviction for FGM⁵⁵. Sokoloff and Dupont (2005) contend that ethnic minority women are often ambivalent about using the police to deal with social problems given the racism, classism and sexism inherent within the criminal justice system. Ethnic minorities have experienced at first hand the effects of overzealous state intrusion in the lives of poor women: police surveillance, incarceration and removal of children from their care (Coker, 2001).

There are also structural barriers that ethnic minority women and girls experience. Girls often have limited access to resources and limited knowledge of the law and therefore are disempowered from seeking support. Cultural barriers might discourage ethnic minority girls and women from reporting family members or escaping situations of FGM when they are dependent upon their family for financial and social status (Crenshaw, 1991: 1248). Language barriers often act as a further structural barrier to the enforcement of law (Crenshaw, 1991: 1249). Members of the community with insecure immigration status may suffer in silence because they fear that seeking help could result in their deportation from the UK. Insecure immigration status increases girls and women's vulnerability and disempowerment (Crenshaw, 1991: 1249).

A further obstacle is that stakeholders are rarely trained in FGM. A failure to understand the law can lead to misguided beliefs that the practice is culturally acceptable, thus stakeholders fear interfering with a traditional practice due to concerns about being branded racist (E. Burman, 2004). A key barrier to enforcement is the lack of a coordinated enforcement plan. The intent of the 1985 Act and 2003 Act was to send a symbolic message to FGM-performing communities that FGM is not tolerated (Rogers, 2013). There was never any consideration of how legislation would be enforced. Without enforcement plans and education initiatives, it is

⁵⁵ Dias QC, D; Gerry QC, F; Burrage, H. (2014). *10 reasons why our FGM law has failed and 10 ways to improve it*. The Guardian. Available at: <http://www.theguardian.com/commentisfree/2014/feb/07/fgm-female-genital-mutilation-prosecutions-law-failed> [Accessed 02.05.2017]

difficult to see how communities and even stakeholders, would be aware that FGM is a criminal offence.

Anti-FGM activists have raised concerns that communities and stakeholders, such as midwives, are not aware of the criminal status of the practice and thus fail to report cases to the police, leaving girls at risk of the practice (Dorkenoo, 1994; Momoh, 2005). In the absence of a coordinated enforcement strategy, NGOs have engaged in community awareness-raising on limited resources (Dustin & Phillips, 2008: 216). Unlike many other criminal offences, FGM is unique in nature as it is a familial and a community practice where the perpetrators are usually parents or relatives of the woman or girl and the woman or girl is unlikely to consider them criminals. Education is imperative to overcome the hurdles of enforcing the law.

Conclusion

This chapter explores the emerging international human rights framework designed to address FGM and define the practice as a human rights violation. Furthermore, the chapter sets out the steps taken by the Government from 1985 to present day to introduce national legislation to prohibit the practice. An intersectional analysis of race, gender, culture and class was used to analyse the impact of the legislative changes upon ethnic minority women's experiences of the law. Political and public discourse accompanying legislative changes was examined to show hyperbole and monolithic narratives of FGM, which were projected onto ethnic minority women. Such narratives could be responsible for rousing racial tensions between ethnic minority communities and law enforcement officers, thus deterring women from seeking support from stakeholders.

This chapter explored the structural barriers that prevent women from seeking support, such as language difficulties and dependence on family members. Furthermore, the chapter examined the barriers that prevent stakeholders from enforcing FGM laws, such as a lack of understanding of the practice and fears of being branded racist. Given the barriers that prevent the enforcement of FGM laws, this chapter shows that legislative changes alone are insufficient to eliminate the practice. The literature review is set out in chapter two and chapter four, five and six consist of the empirical chapters addressing women's and stakeholders' understandings of FGM and their attitudes and beliefs towards anti-FGM law. Research questions derived from themes explored sequentially in the empirical chapters are:

1. What are the motivations for continuing the practice of FGM?
2. What are women's attitudes and beliefs towards the criminalisation of FGM and what impact have the laws had on the dynamics of the practice?
3. What are the barriers to the law deterring and eliminating FGM?

Chapter Two:

Challenges Presented by Polarised Theoretical Debates about Female Genital Mutilation and Anti-Female Genital Mutilation Laws

“The veil becomes what must be removed and her flesh revealed – in the same vein as her flesh must be restored in anti-FGM discourse. In both these representations it is the body of the Muslim woman that requires liberation” (Rogers, 2013: 39).

Introduction

This chapter situates the study of the thesis within academic literature, theory and debates about FGM and anti-FGM laws in England and Wales. Grounding the study in the literature assists in answering the core research question of why FGM persists despite the criminalisation of the practice. This chapter examines the conflicting theoretical positions of feminism, cultural relativism, international human rights and critical race theory. The different theoretical frameworks highlight how mutually reinforcing vectors of gender, race, class, nationality and religion impact upon women’s experiences of FGM and anti-FGM laws. Nash (2008) and Crenshaw (1991) contend that women’s experiences are shaped by other dimensions of their identities such as gender and race, which are often marginalised by scholarly work.

From the outset it is important to note that there are two distinct positions in the literature: the anti-FGM lobby and the critics of that lobby⁵⁶. The critics do not necessarily support FGM, some criticise the anti-FGM rhetoric, which they believe has played a role in demonising

⁵⁶ My personal position with regard to the FGM debate is outlined in the introduction. While I advocate for the elimination of FGM, I recognise the importance of giving a voice to all sides of the debate. It is important to understand each side of the debate including those that defend FGM in order to answer the research question of why FGM persists despite its criminalisation. The aim of this chapter is to provide a well-rounded and rich understanding of the practice as perceived by scholars from different perspectives.

FGM-performing communities (Dustin, 2010: 8). Addressing the limitations of scholarly work is essential, as the literature should be read with caution for the following reasons: debates are straddled across various disciplines with little coherence, publications by scholars outside of FGM-performing communities are subject to criticism because of their outsider status and scholarly work is rarely supported by empirical research, due to limited research studies.

I commence the literature review by exploring the theory of intersectionality and the applicability of the theory to ethnic minority women's experiences of FGM. While there is no literature specifically addressing intersectionality and FGM, there are relevant principles within the literature that can be applied to this thesis. The second part of this chapter reviews the debates of Western feminists who regard the practice as oppressive to women, scholars who criticise Western feminists' portrayal of the practice as patriarchal and African women scholars⁵⁷ who highlight women's agency in *choosing* FGM. The empirical chapters show a divide between women that support FGM and women that seek to eliminate the practice. Women's support for FGM could explain why the practice persists despite its criminal status.

The second part of the chapter reviews the tensions in the historical perceptions of FGM as a cultural practice or an international human rights violation. Exploring the conflicts between cultural relativists and international human rights proponents is integral to examining interview participants' conceptualisation of FGM as either a cultural practice or child abuse. Examining the interview data will show whether stakeholders situate FGM within a

⁵⁷ I have adopted the terms 'Western feminist' and 'African scholars' to distinguish between two groups who approach FGM research from unique political, social and cultural perspectives. 'African scholars' is used to describe scholars of African heritage who critique Western feminist literature about the practice. Some African women scholars do not support FGM but *critique* feminist discourse, while others advocate *for* the practice. The terms are not used to define a homogenous group of people or to lump all African women together. Rather such terms are used to distinguish between scholars who define themselves as feminists and scholars who do not label themselves feminists and actively embrace their African heritage. I recognise that labels are dangerous as binaries can emerge. I try not to fix tight boundaries between scholars and instead explore the blurred and fluid positions of scholars. In other words there are scholars who describe themselves as African feminists and thus fall into both categories as they use Western liberal discourse while also applying an African focused lens. Recognising the fluidity of scholar's positions is imperative to ensure that essentialist depictions of their viewpoints do not emerge.

monolithic human rights framework that legitimises legislative action against ethnic minority communities. In contrast, women are divided between those who sympathise with a cultural relativist perspective and those who view FGM as a human rights violation.

The final part of this chapter draws on critical race theory to analyse whether women's racial identity impacts upon their experience of the law and their access to the criminal justice system. The chapter also explores whether anti-FGM political and media discourse fuels racial divisions and racist sentiments. There is limited literature addressing whether there is a relationship or a tenuous link between anti-FGM discourse and the rise of Islamophobia. However, there is literature reviewing discourses about the abuses of women in minority cultural groups, which misrepresents cultural groups and becomes entangled with anti-immigration agendas (Dustin & Phillips, 2008). The literature criticising narratives about violence against women in minority groups can be applied to FGM, as it explains the barriers women encounter in accessing FGM laws that are shrouded in racist discourse.

Limitations of Scholarly Work on Female Genital Mutilation

Over the last few decades, FGM has been the subject of intense debate amongst scholars. International debates have raged about FGM in the context of cultural relativism, international human rights, racism, Western imperialism, medicalisation, sexuality and patriarchal oppression of women, resulting in much discussion and writing on the issue (Shell-Duncan & Hernlund, 2000: 1). Debates have taken place across different genres of theoretical study. There is not one body of scholarly work on FGM. Instead, the academic literature is scattered, falling into areas of anthropology, epidemiology, history, public health policy, law, social work, psychology, women's studies and political science (Shell-Duncan & Hernlund, 2000: 1). One of the objectives of this chapter is to bring together various disciplines, particularly sociology and law, to highlight connected discussions across what often appear broad disciplines.

Scholarly work on FGM tends to be authored by African and Western academics, which has caused conflict. African and Western scholars have both criticised Western involvement in FGM, arguing that it should be left to the Africans who practice FGM to debate the issue. The emergence of the practice in Western nations has resulted in a public and political outcry against the practice and the eventual implementation of legislative initiatives across the West. Critics have argued that literature about FGM by Westerners has been excessive, essentialising, paternalistic and quasi-racist (Shell-Duncan & Hernlund, 2000: 2). Throughout

this chapter, I bring together a wide range of scholars, both African and Western, to explore their complex and divergent views, arriving at critical positions of support or opposition towards the practice.

The originality of the scholarly work about FGM is contested. Authors perpetuate a cycle of citing former literature or dated anthropological studies and ethnographic fieldwork to support their position instead of citing up-to-date empirical research⁵⁸. Empirical research on FGM in England and Wales is limited to small samples of interviewees and one or two focus groups. As a result, empirical research studies are rarely cited. This literature review could be criticised for citing the same scholarly work that references outdated ethnographic studies. Unlike other papers, this thesis acknowledges the limitations of reviews of the literature about FGM. The literature that is cited is difficult to evaluate because there is no information about the evidence upon which strong assertions are made. As a result there is no basis for evaluating the credibility of these assertions. Where empirical research is available, I provide an overview of the methodology and key findings. This review of scholarly work is somewhat distinct from previous literature reviews because it presents the arguments of various debates, for and against the practice, rather than siding with one perspective, while also outlining the limitations of scholarly work. This chapter seeks to offer an overview of the key arguments, grounds of contention, evidence available and gaps in the literature.

Intersectionality and Identity Politics

The multi-disciplinary approach of this thesis is one of intersectionality. The term emerged in the late 1980s and early 1990s from critical race studies, as a movement committed to criticising the law's colour-blindness, neutrality and objectivity (Nash, 2008: 2). It ensures the non-essentialist framing of women's experiences. The aim is to analyse "the various ways in which race and gender interact to shape the multiple dimensions of Black women's ... experiences" (Crenshaw, 1991: 1244). It exposes the differences within the broad categories of 'women' and 'ethnic minorities,' which show their multiple identities (Crenshaw, 1991: 1296). Intersectionality is the theoretical and practical framing for understanding how the multiple dimensions of race, gender, class and culture impact on ethnic minority women's experiences of issues such as violence. Andersen and Collins (2001) explain that

⁵⁸ Renowned human rights lawyer Gerry QC (2014) provides a holistic review of the literature on FGM.

“analyzing race, class and gender as they shape different group experiences also involves issues of power, privilege and equity. This means more than just knowing the cultures of an array of human groups. It means recognizing and analyzing the hierarchies and systems of domination that permeate society and that systematically exploit and control people” (5-6).

Women’s experiences of FGM and anti-FGM laws are likely to be influenced by their identity and the structural inequality and oppression that they have encountered. I use the approach of intersectionality to analyse how FGM impacts upon women’s lives, which are located within structures of power, inequality and oppression. The aim of this thesis is to make audible the voices of ethnic minority women who have historically been marginalised from debates about issues that impact upon their lives (Sokoloff & Dupont, 2005). This study seeks to explore whether racism is a barrier to women accessing the criminal justice system and service providers for support.

The literature on intersectionality in law and policy is imperative within this study. While there are various axes of inequality, Bilge (2010b) highlights that certain inequalities including class-based inequalities still appear legitimate in law, while race and gender are defined as discrimination (66). Indeed, Uccellari (2008) shows that “discrimination law denies the reality of multiple discrimination” (24). Instead, the law appears to regard individuals belonging to legally defined groups as the same (Uccellari, 2008). For instance, the law defines women and girls from FGM-performing communities as the same. Law and policy has not been designed with an intersectional perspective, as it fails to reflect unique identities and discrimination. For example, anti-FGM laws define girls and women as incapable of consenting to any type of FGM due to coercive cultural pressures without any recognition of nuances in identities. The empirical chapters analyse stakeholders’ attitudes and beliefs towards FGM and anti-FGM laws to ascertain whether they approach the subject with an intersectional lens or whether they view the issue as monolithic.

Feminist Theories and Critiques: Ascribing Agency or Victimhood Status upon Women

The literature has become a site of polarised debate between Western feminists who define the practice as oppressive, scholars who do not support FGM but reject Westerners’ portrayal of the practice as barbarous and African women scholars who argue FGM is a legitimate cultural practice embraced by women. While clear divides between different schools of

thought are visible, there is also overlap and fluidity in the positions of Western feminists and African women scholars who both reject the practice. Some African women scholars have joined Western feminists in their condemnation of the practice,⁵⁹ while criticising Western feminists' portrayal of FGM as torturous. Despite examples of unity between African women scholars and Western feminists, there is largely divergence between Western feminists, who depict FGM as a barbaric cultural practice stemming from the tyranny of patriarchy and African women scholars who argue the practice is a source of power and strength for women. Within the literature, I draw on tensions amongst scholar's understandings of FGM. In the empirical chapters, I apply scholar's work to explore women's conflicting attitudes towards FGM as a gendered practice.

Western feminist literature on the eradication of FGM represents the practice as the sexual subordination and oppression of women (Daly, 1990; Hicks, 1996; Hosken, 1979). Fran Hosken (1979), one of the first FGM researchers, argues that a woman "feels that [her] own personal sense of dignity and worth as a woman and as a human being is under attack by these mutilations" (14). Sociologist Elizabeth Moen (1979) argued that FGM is performed to control women's bodies and thus any movement concerned with liberating women must include the politics of FGM. Western radical feminist⁶⁰ Mary Daly (1990) contends that the "cultural" justifications for FGM, such as initiation into adulthood, serve as a smokescreen to perpetuate male control over women's sexuality. Incidentally, anti-FGM activism coincided with the movement for the liberation of women's sexual desire in the 1970s, when Western feminists discovered their own clitorises and redefined the parameters of sexuality (Rogers 2013). In viewing the clitoris as a powerful symbol of women's sexual liberation, FGM became a symbol of patriarchal oppression, because the clitoris had been mutilated in order to de-emphasise women's sexuality and emphasise their reproductive utility. As stated by Hosken (1979), "the sexual castration of women is the purpose of the operations" (73). In this way, FGM can be seen as a metaphor for the denial of a woman's sexuality, which is locked

⁵⁹ See Abdalla (1982), Boulware-Miller (1985); El Dareer (1982); Gunning (1991, 1997, 1999), and Walker and Parmar (1993). Leading medical stakeholders, Dorkenoo (1994); El Saadawi (2007) and Momoh (2005) supported women affected by FGM and advocated for the elimination of FGM on an international level.

⁶⁰ Following the sex wars in the late 1970s and early 1980s, the feminist movement divided between radical feminists and liberal feminists. The former believed that patriarchy could only be eradicated if the structures of capitalist society were broken down and transformed. Liberal feminists sought to introduce feminist reforms within the patriarchal system to engender change for women.

up with a chastity belt made of her own flesh (Toubia, 1995: 299). The sharp contrast of FGM with women's sexual liberation of the 1970s perhaps incited the wrath of radical Western feminists.

Splits have emerged between Western feminists and African women scholars about the possibility of ascribing autonomy and agency to adult women who practice FGM⁶¹. Western radical feminists Hicks (1996), Daly (1990) and Hosken (1979) contend that it is impossible to exercise autonomy and agency to undergo FGM when their decisions are constrained by oppressive contexts. Although not a radical Western feminist Gunning (1999) an African-American academic, shows that women's agency is undermined when they face extreme sanctions for not conforming to FGM. The social consequences include isolation from family, friends and the community, being treated as a social outcast and viewed as dangerous or dirty for not undergoing FGM (Gunning, 1999: 659).

Criticisms have been levelled at Western feminists for presenting arguments as incontestable facts about a static practice (Dustin, 2010: 9). Western feminists have been heavily criticised for portraying African women as infantile beings who lack the autonomy and agency required to resist FGM. This is exemplified in the following quotation from '*Hosken Report: Genital and Sexual Mutilation of Females*,' "men are responsible for the worsening conditions in Africa: women and children are the abused and voiceless victims" (Hosken, 1979: 112). To readers of Western feminist literature, there is a perception that African women are represented as passive cultural dupes whose sexual and reproductive functions are controlled by men without resistance. However, research into the sexual experiences of women who have undergone FGM challenges preconceived views that it curtails women's sexuality. Malmström (2013) interviewed lower-class women about the practice in Egypt and found that women are angry at the accusation that FGM removed their sexuality and sexual pleasure⁶². Women interview participants argued that FGM heightens and makes their sexual experience holistic. Suggesting that women have not experienced the height of sexual pleasure leads to

⁶¹ Meyers (2000) argues that it is difficult to engage in constructive discussion about consent when the language used to describe the practice is based on mutilation. The condemnatory language of 'female genital mutilation' prejudices discussion about women's autonomy in agreeing to the practice (Meyers, 2000).

⁶² In Egypt FGM is medicalised thus the health complications are not usually as complex as when performed in the private sphere often underground. Without clear public health problems it can make it challenging to argue the practice should be prohibited when met with defiant views of women.

the contentious label of ‘false consciousness,’ projected onto cut women by uncut women, which is met with fierce resistance according to Malmström (2013).

African-American academics, such as Ahmadu (2000), Obiora (1997, 2005, 2007), Ogbu (1997) and Mugo (1997), have attacked Western feminists for the colonialist and imperialist discourse⁶³ in constructing stereotypical images of helpless women denied the choice to not be mutilated. They accuse Western feminists of lacking an understanding of the non-Western meaning of women’s bodies and sexuality (Korieh, 2005). Marie Angelique Savane (1978), President of the Association of African Women published an article criticising cultural insensitivity and calling for Western feminists to reconsider their conceptions of women, women’s oppression and women’s needs in light of cultural difference. The implication is that Western feminism as a discourse and the woman-centred approaches are culturally specific and African women do not support the essentialist and ethnocentric view of women which many Western feminists are accused of perpetuating (Ramazanoglu, 2012).

Obiora (1997) highlights the importance of communities recapturing and controlling the representation of FGM⁶⁴ as a means of resisting Western dominant narrative. Obiora (1997) argues, “women’s control over rituals can be located as a source of strength and power... acting as a religious counterbalance to the secular male power” (303). Anthropologist Boddy also argues that many Sudanese women regard FGM as an “assertive, highly meaningful act that emphasises female fertility by de-emphasising female sexuality” (Boddy, 1982: 682). Western anthropologist Shweder (2004) equated FGM with power and capital amongst women on the basis that FGM is almost exclusively controlled, performed and strongly upheld by women (100).

Scholars argue that it is arrogant of Western feminists to dismiss the consent of African women to undergo FGM as the product of false consciousness or to offer to change the mind

⁶³ African women scholars who condemn FGM have challenged Western feminist discourse on FGM. For example, see *Speak out, Black sisters: Feminism and oppression in Black Africa* written by Senegalese political activist Thiam (1986), and *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*, a volume of essays written by African women scholars and edited by Nnaemeka (2005a).

⁶⁴ Similar to FGM, scholarly work on the Islamic veil shows that women attempted to define their own identities by resisting the meanings attached to the veil by others and emphasising that they had made their own choices, and their choices were not constrained by others (Dwyer, 1999: 13).

of the “Exotic Other Female” (Engle, 1991) in a bid to “rescue Other women” (Grewal, 1998: 512). Sierra Leonian-American anthropologist Fuambai Ahmadu (2000) argues that this position is dangerously arrogant when “the practice is already seen as legitimate by proponents who have themselves undergone excision” (309). The author herself, Ahmadu (2000), underwent FGM as an adult in Sierra Leone and she believes the female-controlled practice is empowering for women:

“It is difficult for me, considering the number of ceremonies I have observed, including my own, to accept that what appear to be expressions of joy and ecstatic celebrations of womanhood in actuality disguise hidden experiences of coercion and subjugation. Indeed, I offer that the bulk of Kono women who uphold these rituals do so because they want to [...] they embrace the legitimacy of female authority and particularly, the authority of their mothers and grandmothers”⁶⁵ (Shweder, 2000: 209-210).

For some anthropologists, including Ahmadu, the Western narrative of FGM as the subjugation of women is part of a legacy of neo-colonialism (Coomaraswamy, 2002a: 492). Obiora (2007) contends that overly simplistic representations of African women as cultural dupes make invisible women’s own acts of agency and resistance in the context of FGM (2007: 71). Women’s acts of resistance in the context of FGM are rarely discussed within the literature.

A prominent and yet rarely cited act of resistance is women’s resistance to anti-FGM laws under colonial rule in Kenya. African-American academic Njambi (2011) contends in her paper, *Irua Ria Atumia and Anticolonial Struggles among the Gĩkũyũ of Kenya: A Counternarrative on “Female Genital Mutilation,”* that the banning of FGM in Kenya mobilised women to engage in anticolonial struggles⁶⁶ from the 1920s to the 1960s (180). Initiation rituals were central to everyday life and thus the ban of FGM sparked women’s involvement in the anticolonial resistance (Njambi, 2011: 182). Women’s resistance to anti-FGM laws symbolised their resistance to colonialism. Women engaged in militant activity in ways that signified their strength and bravery and in turn they were perceived to be coequal

⁶⁵ This quotation comprises part of the speech Ahmadu gave at the American Anthropological association in 1990.

⁶⁶ According to Edgerton (1989), “Mau Mau, the first great African liberation movement, precipitated what was probably the gravest crisis in the history of Britain’s African colonies” (vii).

with men (Njambi, 2011: 180). Women were unable to prescribe an autonomous existence of equality outside of the divergent boundaries defined by either colonialism or anti-colonialist movements.

Scholars argue that African women's resistance during colonial rule, otherwise referred to as Third world women's movements, have been marginalised by Western feminists. Western feminists have been accused of implicitly siding with colonial rulers who supported eradicating FGM, while ignoring the barbarism of imperialism itself (Mohanty, 2003; Njambi, 2011). Colonial rule was cruel to African women. As Edgerton (1989) states, "women were cut, beaten and burned and in addition they had their vaginas stuffed with stinging nettles, penetrated by snakes, or filled with boiling water" by colonial state actors (163). While some Western scholars criticise colonialism, they still depict women who undergo FGM as oppressed (Shaw, 1995).

Njambi (2011) contends that the Western story of FGM is hegemonic and fails to reflect the complexities of women's experiences of FGM in different contexts (180). Njambi (2011) argues that there is a persistent colonial legacy, which is still present today, one that presumes the right of the civilised West to intervene in the cultural practices of the barbaric other (Njambi, 2011: 182). Indeed, anti-FGM laws have been imposed on FGM-performing communities throughout the West even in the face of opposition from immigrant communities. Reflecting on the historical trajectory of women's resistance to anti-FGM laws is imperative to exploring women's resistance to laws prohibiting FGM today. No research studies have explored women's resistance to anti-FGM legislation in the West. Acts of women's resistance to anti-FGM law are examined in more detail in the empirical chapters of this thesis, as this may explain why FGM persists in a context in which it is criminalised.

Western feminists emphasise the need for visible acts of women's resistance to determine their agency. However, simply locating acts of women's resistance is not necessarily indicative of women's agency. According to Bilge (2010a), Western feminists "conception of agency... is deficient, for it reduces agency to resistance" (19). Scholars contend that women can exercise agency in oppressive contexts when resistance is not visible. In her book *'The Politics of Piety,'* anthropologist, Saba Mahmood (2011) explores women's agency within the cultural and ethnographic context of the grassroots women's Islamic piety movement in Cairo, Egypt. She writes that women participants of the piety movement occupy an uncomfortable position in feminist scholarship as they intentionally subject themselves to a set of ideas and practices perceived as subordinate within feminist theory (2011: 5). Mahmood criticises the privileging of Western liberal feminist assumptions that agency be

linked to the resistance of women. She contends that agency can be de-linked from enacting or subverting norms and associated with the choice of Muslim women to uphold patriarchal practices through their actions. In upholding inherently patriarchal norms, women realise the divine path set out in religious texts for themselves. In this way, women exercise agency and choice in oppressive contexts. Mahmood invokes what Foucault calls the paradox of *subjectivation*, the central formulation being that the:

“very processes and conditions that secure a subject’s subordination are also the means by which she becomes a self-conscious identity and agent... Stated otherwise, one may argue that the set of capacities inhering in a subject – that is, the abilities that define her modes of agency – are not the residue of an undominated self that existed prior to the operations of power but are themselves the products of those operations” (17).

Foucault applied the concept of subjectivation to liberal subjects. Now Mahmood applies the definition to Muslim women in the Islamic piety movement. The concept refers to the construction of the individual subject in various contexts, which may be conceived of as oppressive from the outside. Mahmood shows that an individual can still be constructed as a self-conscious agent in a context of subordination. Agency is not only demonstrated through resisting domination but also through action that subordination creates and enables. In this way, a woman is demonstrating her agency through actions of resisting or even accommodating FGM.

Meyers (2000) argues that declaring women who belong to cultural groups that practice FGM devoid of autonomy would be to deny existing opportunities for choice and to erase the real, sometimes courageous choices women have actually made, such as persuading family members not to practice FGM (475). Meyers (2000) contends that women exercise effective agency with respect to FGM, both as *accommodators* and as *resisters* and neither group can be presumed to enjoy greater autonomy than the other (470). Meyers (2000) does not believe that autonomy can simply be determined by analysing the nature of resistance (470). Women can be seen as exercising effective agency in performing and preventing FGM. Indeed, women in the empirical chapters ascribe agency to themselves as perpetrators of FGM.

There is reams of scholarly work criticising academics who argue women exercise agency and autonomy in oppressive contexts. Foucauldian social constructionist Clare Chambers (2008) criticises the privileging of autonomy and choice in oppressive contexts where women’s decisions are constrained. She argues that women are often expected to choose

between undergoing FGM or being isolated from their family and community. In such cases, how can women's choices truly be considered real and free? Chambers contends that a woman's *consent* to FGM is neither real nor viable when an individual is coerced to make choices that disadvantage her (118).

Invoking Foucault, social theorist Sandra Bartky (1997) argues agency and autonomy are often overemphasised by scholars. Bartky (1997) contends that scholars ignore the relationship between why one makes 'choices' and the social influences that impact upon the 'choices' women make. There are a range of disciplinary practices normalised within culture and society to produce a docile body, which in gesture and appearance produce the ideal feminine body (Bartky, 1997: 27). Violation of the norms, or resistance can result in violent social sanctions (Bartky, 1997: 30). Applying Bartky's theory to the practice of FGM, one could argue that FGM ensures a woman's body is a site of reproduction rather than sexuality, which is normalised within FGM-performing communities. Any attempt to resist FGM can result in severe social consequences including the inability to marry and reproduce, which women are reliant on for social status and economic security. In this context, a woman's 'choice' to undergo FGM is constrained rather than autonomous.

The purpose of this part of the chapter is to show the competing voices within feminist literature on FGM. Feminists argue the patriarchal practice seeks to control women and girls' sexuality, while African women scholars contend women and girls' exercise agency and *choose* the cultural practice. The literature is used to interpret the data in the empirical chapters. Similar to scholarly work, there is no uniform position towards FGM amongst women interview participants. Some women adopt a strong anti-FGM position while others defend the practice. The divergence in attitudes and beliefs towards FGM could be one reason for the persistence of the practice in a context in which it is criminalised.

Female Genital Mutilation and Female Genital Cosmetic Surgery: A Legal Double Standard?

Anti-FGM legislation in England and Wales is based on a double standard that has dominated international literature (Dustin & Phillips, 2008: 414). The law tolerates a girl or woman undergoing female genital cosmetic surgery (FGCS) to conform to majority social norms in having the 'ideal' genitalia, while conformity to minority cultural norms in the form of FGM is prohibited by law (Dustin & Phillips, 2008: 414). Increasing numbers of academic studies

compare and contrast FGM and FGCS (Pedwell, 2011)⁶⁷. Exploring the double standard in law assists in answering the research question of why FGM persists in a context in which it is a criminal offence, as this anomaly may be a barrier to the elimination of FGM. Indeed, women interviewees sought to compare the practices as a means of justifying performing FGM and arguing for comparable treatment of the practices in law.

It's important to identify at the outset that there are obvious differences between FGM and FGCS, such as the demographic of women and girls undergoing the practices, the context in which the practices are performed, the purpose and the meanings ascribed to the practices by society. There are also similarities between FGM and FGCS in that the practices involve excision of women's and girls' genitalia for the purpose of conforming to an 'ideal' standard defined by minority or majority cultural and social norms⁶⁸. A key argument for undergoing FGM or FGCS is that women's bodies in their natural state are unattractive and are in need of surgical intervention (Dustin, 2010: 10). FGM is performed due to a cultural belief about beauty and smooth genitalia, which is similar to the justification for FGCS, where women seek prepubescent aesthetic genitalia featured in mainstream advertisements (Dustin, 2010: 11). Like FGM, cosmetic surgeries are carried out to make women fit a 'cultural norm' (Dustin, 2010: 12).

Typically, the domains of FGM and FGCS have been constructed as polar opposites. The Western woman is constructed as superseding the influence of culture, making an autonomous, empowered and authentic choice to undergo FGCS (Gillespie, 1997). In contrast, the question of choice for the non-Western ethnic minority woman to undergo FGM is seen as overdetermined by culture and therefore impossible (Braun, 2009; Sullivan, 2001).

⁶⁷ While the focus of this study is England, it is important to be aware that the growth of the global beauty market is impacting upon the prevalence of FGM across the world. The persistence of FGM also has wider political-economic dimension, which although interesting is outside of the realms of this study. Professor Tamsin Bradley, anthropologist and worldwide expert in FGM at Portsmouth University, informed me that in Sudan private cosmetic clinics have opened and are offering laser FGM treatments promising a 'beautiful polished' appearance. The language of the beauty industry is being co-opted by performers of FGM resulting in new techniques and justifications for continuing the practice. The opening of private cosmetic clinics maps to Sudan's economic decline linked to American and EU trade and economic sanctions. Doctors need to find ways to ensure a salary.

⁶⁸ The intention of the thesis is not to create a binary between FGM and FGCS but rather to explore the fluidity and parallels between the practices.

Comparing and making links between the practices, also known as the ‘analogue approach’ as coined by academic Carolyn Pedwell (2007), has become a way of countering cultural essentialism. The purpose of making links serves different political agendas. Feminists have compared the practices to bolster their argument that FGM and FGCS are oppressive to women and both practices should be criminalised. Defenders of FGM on the other hand have used FGCS to further their argument that if FGCS is tolerated on the basis of ‘individual choice,’ FGM should also be permitted.

African women and cultural relativists connect FGM and FGCS as a means of arguing for the decriminalisation and medicalisation of FGM, like FGCS. They have compared the practices and argue that neither practice is oppressive because the resulting appearance is considered by Western and African women as an improvement of normal genitalia (Korieh, 2005). Some African women do not consider FGM as mutilation just like many Western women do not view cosmetic procedures as mutilation and yet both procedures involve excision. African women argue that if women in the West have a right to express their sexuality and are pro *choice*, then African women should also have the right to choose how they express their sexuality (Korieh, 2005). Scholars have adopted similar language and rhetoric to those that advocate for FGCS, arguing that the practice is a choice, liberating and empowering for the individual woman.

A comparison can be drawn between proponents of FGM who adopted the language of individual choice within the West and Muslim immigrant women in the West who argue that they choose to wear the Islamic veil. The Islamic veil is used as an analogy to explore women’s choices, the meanings projected onto the practices and acts of resistance. Killian (2003) conducted a study⁶⁹ on veiling in France exploring how Muslim immigrant women from North Africa view the veil in France. The findings show that younger educated women view the veil “as a matter of personal liberty and cultural expression” (Killian, 2003: 567). The participants reclaimed the veil as a matter of personal choice. The women interviewed adopted a distinct Western discourse of individual rights and personal freedom to support their position (Shirazi & Mishra, 2010: 46). Similar to the groups of Muslim women from

⁶⁹ 41 first-generation Muslim immigrant women were interviewed in France in 1999. The majority of interviewees were between 17 to 35 years old when they immigrated. One-third could not be described, as observant Muslims while two-thirds were observant Muslims. Their education varied.

France in Killian's (2003) study, the young American Muslim women interviewed⁷⁰ for the study of Shirazi and Mishra (2010) "also used a Western discourse of individual rights and personal freedom to justify their position" (58-59). Women used Western language to justify their choice of wearing the Islamic veil. Ardizzoni (2004) contends that the studies highlight that Muslim immigrant women's identities are hybrid, they are neither completely Western nor non-Western. There is no literature available exploring whether women from FGM-performing communities in the West have adopted the Western rhetoric of choice and individual freedom to legitimise FGM, or even whether they are undergoing genital surgery due to pressures from mainstream society to have the ideal genitalia. This shall be explored in more detail in the empirical chapters of this thesis.

Feminists also draw links between FGM and FGCS, but for a different political purpose. While feminist groups did not raise the legal double standard as an issue when the Prohibition of Female Circumcision Act 1985 was introduced, since the late 1980s feminists have begun to address the cultural arrogance that has seeped through the international campaign against FGM, while FGCS is tolerated (Dustin & Phillips, 2008: 415). There has been a growth in feminist literature linking FGM and FGCS. Indeed, there are concerns that what many view as FGM is currently being carried out at cosmetic clinics under the guise of cosmetic surgery (Dustin, 2010: 13).

Some Western feminists have begun to draw analogies between FGM and FGCS to show that the issue is not just about barbaric Africa and the control of African women's sexuality, but it is about the abuse of women's bodies on a global scale, suggesting that *both* practices are oppressive to women (Davis, 2004; Greer, 1999; Weil Davis, 2002). Western feminists have made links between non-Western cultural practices and Western beauty practices in order to deconstruct the binary of 'liberated uncovered Western woman' and 'oppressed veiled Muslim woman' (Pedwell, 2011: 188-189). Sheila Jeffreys (2005), Weil Davis (2002), and Duits and Van Zoonen (2006) argue that girls wearing the headscarf (or undergoing FGM) and girls engaging in beauty practices (or FGCS) are denied agency and autonomy by cultures that compel them to conform to patriarchal and oppressive norms. The same arguments apply to FGM and FGCS, as both practices are considered patriarchal practices imposed on women to ensure they conform to ideal body types within their communities.

⁷⁰ The study involved 26 in-depth interviews of American Muslim women in the 18-39 age group, living in and around Toled Youno, Ohio and Austin, Texas, over a six-month period. Younger people were selected, as they are believed to be more heavily invested in defining their identity.

The political agenda of the Western feminist analogue thesis is to reconceptualise FGCS as a harmful cultural practice in the West, thus inviting the legal prohibition of FGCS as commensurable to FGM. Western feminists Kathy Davis (2004) and Simone Weil Davis (2002) contend that the practices are linked to ideas about gendered body performance and gendered body norms circulated within communities. The body norms are enforced through feelings of bodily shame when women are unable to conform. In this context, consent to either practice is highly suspect. According to Dustin (2010), one way of facilitating a decline in harmful practices, “would be to argue for the application of consistent principles of choice and the recognition of all non-therapeutic bodily modifications as ‘cultural’” (20). There are variations in how this would work in practice: making a distinction between adults who can choose to modify their bodies and children who cannot, or prohibiting adults and children from engaging in harmful modification, whatever the purpose of such modification (Dustin, 2010: 20). This may be one way of preventing legal double standards.

Making links between FGM and FGCS has become increasingly common amongst scholars, but it is not without criticism. Pedwell (2011) critiques scholars who seek to mobilise a narrative of gendered similarity across cultures and practices. In doing so, scholars slip back into articulations of essentialist cultural difference. Western feminists essentialise women by lumping them into one group based on their gender rather than recognising how intersections of their race, class and culture impact upon women’s unique experiences of FGM. As a result, scholars that seek to compare FGM and FGCS are criticised for failing to provide an intersectional analysis of power based on race, nationality and religion, which have varying implications for women’s agency in the context of FGM and FGCS (Pedwell, 2011). The conflicts amongst scholars in linking the practices of FGM and FGCS is reflected in the diverse attitudes and beliefs of women and stakeholders towards the legal double standard in the empirical chapters.

This study does not seek to reinforce a binary between FGM and FGCS, the former a cultural practice and the latter a practice stemming from capitalist choice. Instead this thesis defines FGCS as a cultural practice rather than as a symptom of modern capitalist society. FGCS has emerged because of wide and deep-rooted discourses and beliefs about beauty. Similarly FGM is also regarded as a cultural practice. It is important that this study provides a nuanced framing of culture. Defining both practices as partly emanating from culture could have the effect of preventing the racial stereotyping of FGM as a barbaric cultural practice that needs to be challenged. This is explored further in the empirical chapters as women and stakeholders make links between the practice on cultural lines. Understanding how women

perceive FGM and FGCS could provide a significant breakthrough to challenging these practices.

The double standard in law is relevant when exploring the research question of why FGM persists in a context in which the practice is criminalised. Dustin (2010) argues that the legal double standard undermines anti-FGM initiatives, as the legal anomaly serves as a barrier to the law seeking to eliminate FGM (7). This is merely an assumption unsupported by empirical evidence. It is not clear within the literature whether FGM-performing communities are aware of the legal double standard. Women and stakeholders' attitudes towards the legal double standard are explored further in the empirical chapters to ascertain whether it is a barrier to the elimination of FGM.

Challenges Presented by the Approaches to Female Genital Mutilation by International Human Rights, Cultural Relativism and Feminism

FGM has been a site of tension between international human rights proponents, cultural relativists⁷¹ and feminists. The fundamental premise of universal human rights is that rights and rules are universally valid across all societies on the basis of human dignity (Donnelly, 1984: 400). A conflict emerges when international human rights laws are set up to protect both the cultural group's right to sovereignty in maintaining tribal group practices, such as FGM and a woman's right not to be violated (Smith, 1991: 2452). FGM is an example of this conflict. Cultural relativists criticise international human rights for excluding the concerns of cultural groups (Brems, 1997: 136). Feminists' argue women are marginalised by international human rights norms (Brems, 1997: 136). Feminists and cultural relativists each want human rights to account for gender or culture. This part of the chapter explores and critiques international human rights, cultural relativism and feminism. The diverse theories explore FGM from the perspective of gender, culture and human rights. The theoretical frames are applied to the analysis of data derived from interviews with women and stakeholders to ascertain their understandings of the practice and why they believe the practice persists despite its criminalisation.

⁷¹ According to Thiam (1986), cultural relativism gained trajectory during the twentieth century, as it was used to support anti-colonialist movements in the non-Western world.

As examined in chapter one of this thesis, the UN and the WHO declined Western and African Women's calls to take action to eliminate FGM for almost two decades on the grounds that FGM is a legitimate cultural practice (Brennan, 1988: 378). Cultural relativists rejected attempts to incorporate FGM within a universal human rights framework because of its emphasis on the individual and the concept of rights (Brems, 1997: 142). In contrast, cultural groups stress obligations, collective rights and reciprocal responsibilities (Brems, 1997: 146). The community is placed above individual interests. Many argue FGM is integral to the identity of African women and tribal groups, as it ensures the rite of passage to adulthood and is linked to a girl's life trajectory of marriage and childbirth. It took twenty years, from 1960 to 1980, for the UN and WHO to conceptualise FGM as a human rights violation. Eventually international treaties defining FGM as a human rights abuse were adopted and ratified by the UK and other nation-states⁷². Complying with nation-states obligations, they introduced domestic legislation criminalising FGM.

FGM is defined as child abuse in the UK. This implies sending offenders to prison and placing children in care, which is "deeply problematic" (Dustin & Phillips, 2008: 417). Cultural relativists object to framing FGM as an abuse of human rights and the rights of the child. Boulware-Miller (1985) argues that:

"to challenge female circumcision as a violation of the rights of the child suggests that women who permit the operation are incompetent and abusive mothers who, in some ways, do not love their children" (166).

Western Anthropologist Shweder (2000) contends that defining FGM as child abuse has significant implications for branding FGM-performing communities as barbaric:

"the alarming claims and representations by anti-FGM advocacy groups (images of African parents routinely and for hundreds of years disfiguring, maiming and murdering their female children and depriving them of capacity for a sexual response) have not been scrutinised with regard to reliable evidence" (212).

Cultural relativists argue that describing African parents as "mutilators" or "torturers" of their own children, "wittingly or unwittingly represents African adults as either monsters or as ignoramuses who do not appreciate the welfare consequences of their own child-rearing customs" (Gunning, 1999: 673). Scholars contend that defining FGM as a human rights

⁷² See chapter one for an overview of the applicable international treaties.

violation produces ‘racist visionaries’ of mothers as child abusers (Werbner, 2013: 454). Producing visions of brutal and barbaric cultural practices being inflicted on helpless girls could feed racist narratives that results in negative consequences for FGM-performing communities:

“racist folk devils are no mere illusions and fantasies. They represent deep-seated, atavistic, real fear, displaced onto strangers and what strangers come to represent symbolically” (Werbner, 2013: 454).

Scholars have drawn on the unintended consequences of labelling FGM as a human rights violation. Labels can result in stereotypes and racist narratives forming and being projected onto FGM-performing communities. Unintended consequences can also stem from criminalising the practice of FGM in Western countries. Unfortunately there is limited literature about the consequences of criminalising FGM in England. Literature tends to focus on France, perhaps because there have been high profile excision trials with stringent sentences⁷³. France is the only European country to have secured over 100 prosecutions for the practice (Rahman & Toubia, 2000). The law that is applied in France is Article 312, *Alinea 3*, of the Penal Code. This law concerns a range of violent acts committed against minors and the section applies in cases of FGM reads as follows:

“Whoever beats or otherwise voluntarily inflicts violence upon or assaults a child of under fifteen years of age, excluding minor violence, will be punished as follows:... By imprisonment of between ten and twenty years if there has been mutilation, amputation, or deprivation of the use of a limb, blindness, loss of an eye, or other permanent disability or unintentional death” (*Code penal*, 1983-84, 184).

The number of prosecutions is not a yardstick for deterrence and prevention. Criminalising FGM is linked to a dark history of the West’s involvement in banning the practice in parts of Africa during colonialism. The anti-colonial arguments against criminalising FGM in Africa during the 1940s are reiterated again today, this time in Western nation-states that have criminalised the practice. Bronwyn Winter (1994) in her paper, ‘*Women, the law, and cultural relativism in France: The case of excision*,’ argues FGM stands out as a crime because it is directed towards an immigrant community often from former British colonies (Winter, 1994:

⁷³ While the literature focuses on the experience of France, it provides a practical and theoretical framework for assessing the impact of criminalisation in England in the empirical chapters of the thesis.

940). As a result debates regarding FGM in the West are marred by issues of cultural diversity, respect for minority cultures' customs and the status of immigrants (Winter, 1994: 940). The excision debate in France is linked to a reaction against the abuse of a non-dominant class by the dominant class (Winter, 1994: 940). While the pro-criminalisation feminists concentrated on excision as the abuse of girls, cultural relativists saw criminalisation campaigns as continuing the abuse perpetrated by Western powers that sought to colonise the 'other' (Winter, 1994: 940). Gunning (1991) cautions against an arrogant gaze of the Western outsider and contends that the most effective approach to eliminate FGM is a grassroots approach, providing education as well as health initiatives supported by the international community rather than led by the community. Indeed, efforts that have been successful are movements against FGM within FGM-performing countries abroad ⁷⁴ (Brennan, 1988: 379).

Prosecuting FGM raises acute problems that do not exist for other criminal offences. One of the most obvious is that the offender is likely to be a parent or relative of the woman or girl, and they are unlikely to perceive their relatives as criminals (Dustin & Phillips, 2008: 417). Women may wish to uphold the cultural practice and therefore fail to report cases. Cases that do go to trial in France often result in one of the two following defences being raised. The first is: "these poor illiterate Africans don't know any better" ploy, where lawyers and defendants maintain immigrant communities were ignorant of the laws in France (Winter, 1994: 948). Lawyers reinforce negative stereotypes of immigrant communities to their immediate advantage but to the communities' long-term disadvantage (Winter, 1994: 948). The second defence strategy is that perpetrators of FGM are acting according to their cultural traditions that in their minds carries the weight of a law that they are bound to obey (Kymlicka et al., 2014; Winter, 1994). In this way, FGM is not mutilation, or the subjection of women to a patriarchal practice, instead it is culturally acceptable because it allows girls to become women and members of a cultural group in which they can marry and reproduce.

Kymlicka et al. (2014) argue that the link between cultural diversity and criminal law cannot be overlooked by the criminal justice system (1). First, the scholars question whether cultural practices should be exempt under criminal laws. Second, they question whether individuals should be permitted to put forward a cultural defence or mitigation (1). Kymlicka et al. (2014) argue that religious or cultural factors are capable of influencing individual's thoughts and

⁷⁴ See for example Tostan International and the Orchid Project. Both programmes work in FGM-performing countries to encourage communities through education and awareness raising to *choose* to abandon the practice themselves.

behaviour in ways that mean individuals are “less legally blameworthy” (3). In understanding how the courts assess personal blameworthiness, Kymlicka et al. (2014) argue that cultural socialisation relates to judgments of individual responsibility (7). Someone who is deeply embedded in a minority culture may feel morally compelled to act in a certain way, which could excuse or mitigate the crime (Kymlicka et al., 2014: 8). Lacey (1998) takes a nuanced approach in comparing cultural influences with other influences such as poverty or family breakdown, for example, a victim of a poor upbringing may be viewed as less culpable. Applying the same principle to cultural influences, culture may have influential explanatory potential (Sokoloff & Dupont, 2005). The problem with a cultural defence is that it stereotypes entire cultural groups as responsible for abusing women, which stirs racist discourse and anti-immigration rhetoric (Gallin, 1993; Sokoloff & Dupont, 2005). In the empirical chapters, women draw on their attitudes towards a cultural defence for FGM, some robustly arguing *for* a defence recognising the legitimacy of FGM as a cultural practice.

Cultural relativism is subject to extensive academic criticism. Winter (1994) draws on two paradoxical arguments made by cultural relativists. First, Winter (1994) contends that the cultural relativist position is also based on Western liberal principles. For example, cultural relativists argue for a “private choice” and an intrinsic “right” to exist and to “express” themselves “freely” (Winter, 1994: 960). According to Winter (1994) this appears to be a cross-cultural extrapolation of the classic liberal discourse of *his* right to make a free choice. Second, advocates of cultural relativism appear to be white Western men and women who sympathise with arguments from anti-racist movements, thus they assume a new position of intellectual and political power in advocating on behalf of cultural groups (Winter, 1994: 959). According to Winter (1994) Western men benefit from gaining support from minority men to maintain a divide between the public and private domain, which preserves male’s power and perpetuates the marginalisation of women and minority groups (960).

A further criticism of cultural relativist theories is that they are usually culturally reductive perceiving FGM as purely a cultural trope. This in turn, as demonstrated above, supports the emergence of racialised interpretations in which whole cultures are rendered backward or barbaric. Academics Shell-Duncan and Hernlund (2000) have been criticised for taking a cultural relativist stance in their ethnographies about FGM to the extent that their work is perceived as protecting or even upholding the practice. While neutrality is important, a researcher is in a position to push boundaries, to analyse and to interpret data from diverse theoretical positions. However, cultural relativism in anthropology today is used to support critical readings of cultural practices and the dynamics that maintain them. Cultural relativism is a useful tool for collecting deep insights into sensitive and difficult subjects from a

perspective that values culture. I aim to use this approach within my thesis. The theories of cultural relativism and human rights are applied to the analysis of women's and stakeholders' conceptualisation of FGM as a cultural practice or human rights abuse and whether this impacts on their attitudes towards anti-FGM laws.

Feminism's Scathing Critique of International Human Rights and Cultural Relativism towards Female Genital Mutilation

There is a growing body of literature that attempts to address the problem of international human rights and cultural relativism in neglecting women's rights. Bunch (1990) critically examines governments and human rights organisations for not classifying women's rights as human rights despite a clear record of deaths and women's rights abuses (486). The history and development of international human rights could be viewed as the inclusion of men to the exclusion of women. Feminists criticise universal human rights, which stem from the notion of the "rights of man," which was originally conceived by white, male, liberal thinkers who excluded women (Brems, 1997: 137). White men reigned supreme in designing and enforcing universal human rights across the globe upon people who had been denied access to constructing such rights and laws. Human rights can be seen as reflecting the values of Western white men. Bunch (1990) argues white men possess the power to determine universal human rights, which results in a "structural relationship of power, domination and privilege between men and women in society" (491).

There is an inherent bias within international law against non-Western cultures and women whatever their racial or cultural background (Gunning, 1991: 193). Postmodernists argue that reason, knowledge and truth cannot be neutral or objective when they are designed by a select group of people in the service of power (Smith, 1991: 2473). Recognising the evolution of international human rights as male centric is essential for developing a fundamental critique and refashioning international human rights to define abuses against women as violations of human rights. Feminists have spent decades expanding the definition of human rights to incorporate women.

Cultural relativism is also subject to scathing criticism by feminists. Tensions emerge when culture dictates norms that undermine women's advancement. Feminists view human rights through a gendered lens and cultural relativists apply a cultural perspective (Brems, 1997: 147). Feminists view cultures as male dominated and cultural practices as male created. Culture and religion are often the basis of criticism as domains of male domination and

female subjugation (Brems, 1997: 147). Okin (1999) in *'Is Multiculturalism Bad for Women?'* argues sexist cultures that promote veiling, polygamy, child marriage and FGM should become extinct:

“[people] *might* be much better off if the culture into which they were born were... to become extinct (so that its members would become integrated into the less sexist surrounding culture)” (22-23).

Winter (1994) criticises cultural relativism for tolerating “different” expressions of male domination in “other” cultures (958). Feminists argue cultural relativism is a smokescreen that enables governments and citizens to legitimise the oppression of women (Lewis, 1995: 9). Similar to cultural relativists, human rights proponents resist defining women’s rights as human rights because of concerns this would expose the private sphere to state scrutiny. Taking a Western liberal perspective, turning a blind eye to violations of women’s rights is permissible to ensure the right to privacy is maintained. Feminists advocate that women’s rights can only be incorporated into human rights if the distinction between public and private actions is eradicated (Kim, 1993: 49). As a result of the public/private dichotomy underpinning human rights theory, practices that impact on women are defined as “cultural” and thus escape international attention (Kim, 1993: 104). This could include the “private” and “cultural” practice of FGM.

Cultural relativists view feminism and human rights as Western liberal concepts that are used “to further expand Western cultural hegemony” (Kim, 1993: 49). For example, they claim that feminist notions of “autonomy, personhood and privacy are Western concepts without relevance, or without the same relevance, in societies with different values and norms” (Kim, 1993: 60). As Kim (1993) argues cultural relativists’ criticism of feminism as an extension of Western ethnocentrism is “misguided because gender oppression is systematic and cross-cultural” (49).

In attempting to find common ground between cultural relativism and feminism, Coomaraswamy (2002a) highlights that movements advocating women’s rights in respect of minority cultures must recognise a historical colonial legacy, which tars any struggle for women’s equality with western imperialism (487). Gunning (1991) notes that the development of human rights laws needs to be the result of multicultural dialogue and consensus and the implementation of laws must favour education rather than punishment (193). Gunning (1991) argues the problem of arrogance is not the adverse reaction to FGM,

but the way horror is expressed and the solutions that are proposed (199), such as criminalisation.

This part of the chapter reviewed the theoretical positions of international human rights, cultural relativism and feminism and how they relate to the practice of FGM. This provides a core foundation for the analysis of interviews with women and stakeholders. The empirical chapters show women's and stakeholders' understandings of FGM as a cultural, human rights or feminist issue and whether this impacts upon their attitudes towards the criminalisation of the practice. The divergence in women's and stakeholders' understandings of FGM as a cultural, human rights or feminist issue could be one reason for the persistence of the practice in a context in which it is criminalised. This assists in answering the overarching research question of why FGM persists when it is a criminal offence.

The Impact of Race and Racism on Women's Experiences of Female Genital Mutilation

Within this literature review the focus so far has been on gender, sexuality, culture and human rights. In the final part of the literature review, I highlight the intersection of FGM, race and racism. Intersectionality seeks to explore the race and gender dimensions of ethnic minority women's experiences of FGM. Discourses of international human rights, cultural relativism and feminism as considered above have failed to account for intersectional identities of ethnic minority women (Nash, 2008). This part of the chapter explores the West's conflation of FGM as an Islamic practice and the link between anti-FGM narratives and Islamophobia. The focus is on ethnic minority women's experiences of racism and cultural discrimination stemming from anti-FGM sentiments and the impact this has had upon their attitudes to the criminalisation of the practice. This chapter examines the literature on stakeholders' responses to providing support to women from ethnic minority backgrounds who have experienced violence. By way of comparison, scholars' research on ethnic minority women's experiences of seeking help and support from stakeholders for violence is addressed. The purpose is to explore how systems of power in terms of race, class, gender and culture impact upon the service provision of support for ethnic minority women (Sokoloff & Dupont, 2005). Race and racism emerge as key themes in the empirical chapters, thus a review of the literature is essential when analysing the interviews.

The Relationship between Anti-Female Genital Mutilation Discourse and Islamophobia

Although scholars tell us FGM is not a Muslim practice this is an ongoing theological debate with communities. It would not be an overstatement to say there is a wide-scale perception in the West that Islam and FGM are synonymous (Rogers, 2013: 38). According to Rogers (2013), the conflation of Islam and FGM reinforces an image of barbaric Muslims mutilating women (38). In turn, this could give rise to the hatred of Islam, which is perceived as a religion that brutalises women. The hatred of Muslims is referred to as Islamophobia.

Islamophobia is a new form of racism. Historically, we have seen a change in the signifiers that are used to typecast people. Wilson (2007) notes that populations were in the past identified by their physical characteristics, language or region of origin, but now they are first and foremost identified by their religion. Muslim has become a new ethnicity (Wilson, 2007: 31). Rather than relying on physical characteristics to highlight difference, people tend to stereotype Muslims on the basis of religious and cultural signifiers, usually clothing (Marranci, 2004: 106). Changes in the method of stereotyping people has led to an “evolution in racist practice and discourse from overt to implicit,” from biological to psychological (Werbner, 2013: 451), creating a new racism (Stoler, 1997: 371).

Academics have conceptualised Islamophobia as a new form of racism that has emerged since the terror attacks in the United States on 11 September 2001 and is based on an “unfounded fear of Islam” that results in hostility and discrimination against Muslims (Khiabany & Williamson, 2008: 77). In practice, Islamophobia involves misrepresenting the Muslim world to accentuate its difference to the West, for example, reproducing sensationalist images of Muslims as violent terrorists (Marranci, 2004: 107). Racist stereotypes are formed out of “images of inhuman violence” and a belief that people have the “capacity for cruelty and violation” (Werbner, 2013: 451). Werbner (2013) argues that:

“A key feature of racist imaginaries that is left uncaptured by the notion of discourse is the visceral, highly emotional charge of racist images and narratives for both perpetrators and victims...” (451).

Similarly, anti-FGM campaigners use highly charged images of girls being mutilated to highlight the need to eliminate the practice (Rogers, 2013). Applying the racist imaginaries theory of Werbner (2013) to anti-FGM narratives, visceral images of mutilated clitorises in the public consciousness could arouse racist stereotypes of Muslims as child abusers. According to Rogers (2013) anti-FGM discourse and legislation is less based on evidential facts of harm caused to girls than the imagined harm invoked by stories of mutilated girls

(24). Having read through the debates in the Houses of Parliament in the 1980s and around 2003 during the legislative changes to FGM, the debates were emotionally charged and aroused provocative images. Baroness Masham of Ilton described FGM in the House of Lords as cruel, mutilating and horrific. Baroness Gaitskell said in the House of Lords recorded in the UK *Hansard* debate on 10 November 1983:

“We are doing very well by them in allowing them to live in this country. It is nice for them and it is nice of us to do it. But we do not have to import their kind of rules. The point is that such people are not in a position to teach us anything about sexual behaviour.”

FGM discourse plays a role in the polarisation between ‘us’ – freedom in the West – and ‘them’ – victims of oppressive cultures/religions (Dustin, 2010: 11). The anti-FGM campaign can be seen as stirring racist sentiments due to its polemical nature and hysterical and ethnocentric tone in comparison with other campaigns against violence against women for example, domestic violence and rape that are not considered ‘traditional’ or ‘cultural’ issues (Dustin, 2010: 11). Western concern for FGM can be “perceived as only thinly disguised expressions of racial and cultural superiority and imperialism” (Gunning, 1991: 213), which can lead to racist assumptions of cultural/religious groups. Indeed, the public representation of violence in cultural groups is pervasive and inherent. The rhetoric about anti-FGM has the unintended consequence of reinforcing this representation of FGM. Unfortunately scholars have failed to analyse whether there is a link between anti-FGM narratives and racism. The empirical chapters explore women’s and stakeholders’ attitudes towards whether there is such a link.

Racist Stereotypes of Muslim Women and the Rise of Islamophobia

To the best of my knowledge there is a lacuna in the literature addressing whether FGM has become a source for racism. However, I propose to apply scholar’s work on the link between the wearing of the Islamic veil and racism by way of analogy⁷⁵. I examine the relationship between the wearing of the Islamic veil and racism in order to explore whether FGM has

⁷⁵ Veiling and FGM are different practices. Muslims view the veil as an Islamic practice, while FGM’s Islamic roots are heavily contested amongst theologians and FGM-performing communities. FGM is a practice that occurs in the private, while veiling is a public expression of religion. Despite the obvious difference between the practices, the Islamic veil and FGM are conflated as Islamic practices that are performed on women’s bodies.

become a source for racism in the empirical chapters of this thesis. The starting point for exploring the link between the Islamic veil and racism, is examining societies' dominant readings of the wearing of the veil. Societies' varied interpretations of the Islamic veil can serve to explain the rise of racist reactionaries. Women are regarded as refusing to conform to the Western way of life or they are viewed as the 'oppressed' veiled Muslim woman. In the interviews with women and stakeholders, I examine whether these dominant readings of women wearing the Islamic veil also apply to women undergoing FGM.

Bilge (2010a) opines that there are "two dominant readings of the Muslim veil, as a symbol of women's subordination to men, or as an act of resistance to Western Hegemony" (9). The first dominant reading of the Muslim veil as a symbol of women's status as victims has been pervasive throughout history. Similarly, the link between Muslim and mutilated underpins a historical need to rescue Other women from oppressive religion (Rogers, 2013: 39). The unveiled face and the mutilated clitoris become signifiers of the violence performed on Muslim women (Rogers, 2013: 39). FGM is regarded as a barbaric practice forced on women whom have no agency and are in need of being rescued from Islam. According to Rogers (2013), Muslim women are represented as in need of liberation:

"The veil becomes what must be removed and her flesh revealed – in the same vein as her flesh must be restored in anti-FGM discourse. In both these representations it is the body of the Muslim woman that requires liberation" (39).

The body of the Muslim woman becomes a site that needs to be conquered in a war between the West, and Islam. The victimhood narrative of the veil has created an unexpected response of resistance from Muslim communities. In reaction to the subordination thesis, which denies veiled women's agency, a new thesis has emerged making visible the autonomy of women denied agency in the past, which "underline their ability to resist/subvert Western hegemony" (Bilge, 2010a: 10). In practice Muslim women's resistance to the subordination thesis plays out by women wearing the Islamic veil to show their agency and reject Western norms. In the empirical chapters I explore whether women organise to resist the Western prohibition of FGM by subverting the law and continuing the practice underground.

Previous readings of the veil conceptualised women as passive victims of patriarchal religion and culture, but today the veil is seen as a threat to Western modernity, as it represents the 'clash of civilization' and the peril of multiculturalism that should be curbed by coercive action against Islam (Bilge, 2010a). Similarly, narratives depicting FGM interchange and overlap from women being portrayed as victims, to the practice being defined as a threat to

Western civilization. After 9/11 the Western gaze upon the veiled woman was transformed from victimhood to a dangerous woman through the Islamophobic gaze (Khiabany & Williamson, 2008: 83). The veil is perceived as an act of refusal and/or an act of resistance to Western hegemony (Khiabany & Williamson, 2008: 77). The visibility of veiled bodies in Britain invokes racist discourses about threats to British culture, extremism and terrorism, in a context of war with Islam (Khiabany & Williamson, 2008: 77)

Data collected⁷⁶ from Measuring Anti-Muslim Attacks (MAMA) in the UK showed that increased fears of ‘Muslims’ and ‘Islam’ “exacerbated various pre-existing prejudices that in turn fuelled acts of anti-Muslim hate” (Allen, Isakjee, & Young, 2013: 1). For over a decade, Muslim women have been victims of racist abuse because of their distinct identification of being Muslim (Allen et al., 2013). The research study shows that Muslim women accounted for 58% of all incidents reported to it and of those 80% were visually identifiable by wearing the hijab, niqab or other clothing associated with Islam (Allen et al., 2013). A research team from the University of Birmingham collaborated with MAMA to interview 20 British Muslim women who had been victims of Islamophobia over the past year and the findings highlight Muslim women’s experiences ranged from random incidents of verbal abuse in public to intimidation and threats in public spaces (Allen et al., 2013). Muslim women spoke about their “feelings of exclusion and separation, of not belonging to Britain” or British society (Allen et al., 2013: 1).

There are complex reasons women wear the veil including personal reasons, religious identity and a political expression of opposition to racism. To understand the significance of the veil as a political choice for Muslim women, it is important to acknowledge the historical trajectory of the veil before 9/11 (Dwyer, 1999: 7). The image of the oppressed and veiled Muslim woman was used by British and French colonial empires to justify new wars in a bid to liberate women (Haddad, 2007: 259). For women, the veil became a symbol of “anti-colonial solidarity and resistance to efforts to eradicate Islam” (Haddad, 2007: 253) during the revolution and anti-colonial struggle in Algeria in the 1950s and Iran in the 1970s and now in the West (Bullock, 2002: 87). Similarly, FGM became a symbol of anti-colonial solidarity and resistance in parts of Africa as colonial regimes imposed a ban of FGM. Despite the

⁷⁶ In-depth interviews with 20 British Muslim women who had been victim of anti-Muslim hate. 19 identified themselves as looking Muslim visually identifiable, 15 wore a headscarf or hijab, four wore a niqab or full-face covering and one interviewee did not believe she looked Muslim. Ages ranged from 15 to 40. Ethnicities included Pakistani heritage, Bangladeshi, Arab, Somali and White British ethnicities.

British empire criminalising FGM in Sudan in 1949, Sudanese women sought to reinforce the cultural practice and resist the law (Brennan, 1988: 379). Consequently, most of the colonial efforts to ban FGM were abandoned during the 1940s and 1950s.

Events that occurred during colonialism are still unfolding today in the West. Yegenoglu (1998) contends that Muslim women have made a ‘political choice’ to wear the veil post 9/11. Empirical findings from the study of Shirazi and Mishra (2010) shows that women who wear the niqab, often younger women, wear it as an “expression of Islamic identity” post-9/11 and as a “form of rebellion” against the wars in Iraq and Afghanistan and policies at home (50). They wear the veil to “contest social exclusion and anti-Muslim racism by publicly branding oneself a Muslim and displaying an outward sign of solidarity with Muslims in the post-9/11 climate of rampant Islamophobia” (Yegenoglu, 1998: 121).

Findings from research⁷⁷ conducted by Haddad (2007) shows that the process of re-Islamisation has accelerated since 9/11 as second generation young Muslim women in the United States are wearing the veil and assuming a public Islamic identity that subverts Western demonisation of Islam and the degradation of women. A veiled Muslim woman can be seen as becoming “part of the great anti-imperialist Islamic movement” (Afshar, 1994: 143). The refusal of Western society to acknowledge the oppression of women by colonialism and by racism today has resulted in resistance of Muslim women to racist representations of indigenous customs (Bilge, 2010a; Yegenoglu, 1998). While Muslim women aim to control the meaning of the veil as a symbol of resistance, it is perhaps impossible to escape dominant meanings attached to the veil (Dwyer, 1999: 19, 21). As already noted, there is no literature addressing whether women may have made a political choice to perform or undergo FGM in a context of rising levels of Islamophobia. Scholarly work examining the wearing of the Islamic veil as a political choice to resist Islamophobia is directly relevant to the empirical chapters of this thesis, as some women argue that FGM is performed for political reasons, as a means of resisting Western norms and criminal prohibition.

When Law and Policy Fuels Islamophobia

⁷⁷ The paper is based on two decades of research on American Muslim communities in various parts of the United States including interviews with 30 young Muslim women at community events, two focus groups of students at University and a review of the literature (Haddad, 2007: 254).

As the government's response to FGM is part of the research study, the intersection of race, law and policy is relevant. After all women's experiences of FGM are linked to broader structural factors including the law, which can create multiple layers of oppression and racial and gendered hierarchy within women's lives that impacts upon their experiences of FGM (Menjívar & Salcido, 2002: 900). While there is no literature addressing the impact of government anti-FGM law and policy on women's experiences of FGM and Islamophobia, there is ample scholarly work examining the impact of banning the wearing of the Islamic veil. Parallels can be drawn between the contentious question of whether veiled women should be tolerated or outlawed in public space and the question of whether FGM should be permitted or prohibited in Western society. The veil and FGM raise questions of citizenship, belonging and identity.

France is a notorious example of a secular country that has criminalised the veil and prosecuted more cases of FGM than any other country (Winter, 1994).

In public debates on veiling in France, many view veiling as a public violation of secularism and a sign of contempt for French identity by those who practice Islam (Scott, 2009: 15). According to Shirazi and Mishra (2010), arguments of secularism are a guise for the perceived threat of Islam, which plays out in criminalising the veil (46). As early as in 1989 a headmaster of a school in Creil, near Paris, excluded four Muslim girls from school because they refused to remove the veil (Marranci, 2004: 111). The girls represented segregation from mainstream society and refusal to integrate or assimilate into French society and so they became 'aliens' of their society (Marranci, 2004: 111). Those defending Muslims respond by speaking of "secular fundamentalism" (Asad, 1993; Werbner, 2013). While the protection of secularism is grounded in a commitment to equality, it may easily encourage a "new" racism because it provides racists with a legitimising discourse against Muslims (Werbner, 2013: 458). For example right-wing political parties exploit anti-Muslim discourses to ban the wearing of the Islamic veil to license racial attacks (Werbner, 2013: 458).

Rather than unveiling women, anti-veil laws could have the opposite effect of Muslim women resisting the law by adopting the veil. As Marranci (2004) says, "the experience of colonialism has showed that the enforcement of cultural changes are rarely successful and more often dangerous" (112). It is important to acknowledge how cultural practices including veiling and FGM have "acquired their power in part through being fostered as cultural practices of resistance to colonialism and imperialism" (Erica Burman, 2005: 534). Indeed, England has had limited success in reducing the prevalence rate of FGM through its criminalisation, arguably because of the perception of a liberal state reflecting homogenous

values of the white majority and imposing its values on immigrants that need to be civilised to our level (Dustin, 2010: 19). Indeed, government policies designed to curb FGM could have provoked resentment and hostility amongst FGM-performing communities according to Dustin and Phillips (2008):

“In July 2002, for example, the Sheffield Area Child Protection Committee wrote an open letter to all Somali parents warning them to reconsider if they were planning to take their children on holiday to be circumcised...By July 2007, there had still been no prosecutions under the 2003 Act and the London Metropolitan Police had taken the remarkable course of offering a maximum £20,000 reward for information leading to a prosecution” (416).

Policies designed by the dominant and powerful in society to target and change the practices of marginalised minority groups could result in reinforcing the very practices that society seeks to eradicate. Rogers (2013) argues anti-FGM laws were implemented in the face of community objection and thus the law is unlikely to achieve eradication of the practices (23). While there is no empirical research validating or dismissing the arguments of scholars, the theoretical insights provide a framework for analysing interviewees’ accounts of why they believe FGM persists in a context in which it is criminalised.

The Case for Competent Services for Survivors of Female Genital Mutilation

Women exposed to FGM may seek support from domestic violence service providers and other stakeholders, such as the police. Given that FGM is linked to intersectional issues of race, culture, gender, nationality and religion, it is important to examine the impact of these dimensions of women’s identities upon stakeholders’ responses to requests for support and women’s experiences of seeking support. Unfortunately there is no literature specifically addressing the practice of FGM, however there is literature and research on domestic violence. The literature on service user experiences and service providers’ responses to domestic violence support, is examined to assess whether assumptions about culture, race, gender and religion result in obstacles to women receiving support from services.

In a journal article titled, ‘*‘Culture’ as a barrier to service provision and delivery: domestic violence services for minoritised women,*’ Erica Burman, Smailes, and Chantler (2004) address how domestic violence services provided to women of different ethnic, cultural and religious backgrounds are structured by assumptions about ‘culture’ which produce barriers to

the delivery of services for women (332). The scholar's research involved interviews with service providers and service users. A key finding of the research study was that minority ethnic women often find themselves excluded from such services because domestic violence is excused for "cultural reasons" (Erica Burman et al., 2004: 332). The violence is excused because of assumptions of "cultural privacy" in minority communities, which renders the violence less visible and justifiable on cultural grounds (Erica Burman et al., 2004: 332).

Mainstream service providers experience anxieties about engaging with race and cultural issues in contexts where women experience domestic violence (Erica Burman et al., 2004: 336). Service providers acknowledged pressures to privilege community membership over women's abuse, which was presented as peculiar to minority groups rather than recognising it as dynamic in dominant communities (Erica Burman et al., 2004: 337). While women from minority backgrounds might be encouraged to stay in abusive relationships because of their community membership, women from dominant communities were encouraged to remain in violent relationships for the sake of children and family (Erica Burman et al., 2004: 337). Organisations are guilty of denying the existence of domestic violence, failing to ask relevant questions and not believing women's stories (Erica Burman et al., 2004: 337).

Social policy and public discourse drawing attention to minority women's plight highlights both the racialised stereotypes of the ordinary nature of violence in patriarchal communities and the extraordinary features of women subject to primitive practices such as FGM (Erica Burman et al., 2004: 336). Cultural or racial explanations for domestic violence, overlook violence and problematise culture and race (Erica Burman et al., 2004: 340). Ethnic minority women are highly visible in their communities and outside their communities (Erica Burman et al., 2004: 333). Erica Burman et al. (2004) refers to this phenomenon as ethnic minority women's "pathologised presence" in mainstream society (333). Aware of their pathologised presence and race based stigma, minority women can be deterred from seeking support outside of their communities (Erica Burman et al., 2004: 333). Women reported fears of fuelling racism towards their community by disclosing domestic violence, and fears of encountering racism (Erica Burman et al., 2004; Crenshaw, 1991; Sokoloff & Dupont, 2005). Minority women who did seek support reported experiencing racism from services who failed to take their reports seriously, and treating domestic violence as an opportunity to regulate minority communities (Erica Burman et al., 2004: 338).

Erica Burman et al. (2004) also found that reputation was used as a method of regulating women's behaviour and their responses to domestic violence (339). Fears of being outcast from their family and/or community acted as a deterrent to women seeking support for

domestic violence. Seeking services outside of one's community symbolised breaking with tradition, which could result in sanctions in the form of ostracisation. The authors succinctly summarised the conflicting feelings of many survivors of domestic violence who sought support:

“For many survivors it was the loss of this community as well as the fear of isolation and racism within majority communities which stopped them moving on. The complexity of community as both a longed-for resource as well as sometimes a site of oppression for women was not always acknowledged by providers” (Erica Burman et al., 2004: 344).

Women reported that service providers failed to acknowledge the danger inherent in returning to communities, which regarded them as shameful:

“Women were sometimes blamed for bringing the whole community into disrepute... members within the community told them: “you have disgraced us”” (Erica Burman et al., 2004: 347).

Instead of channelling limited resources into supporting women, service providers worked with male community leaders to ensure they did not offend the community. In this way, service providers privileged race over gender. Working directly with those responsible for turning a blind eye to domestic violence reinforced patriarchal power relations within minority communities making domestic violence more invisible (Bradley, 2011; Erica Burman et al., 2004: 347). Anthropologist Bradley (2011) argues that in providing funding to patriarchal community leaders under the banner of “multiculturalism,” the Blair controlled Labour government showed a preference for cultural respect, which reaffirms silence towards domestic violence within communities. The government and community leaders are not the only people responsible for turning a blind eye to violence in minority communities. As noted by one interviewee within the academic paper:

“The police did not get involved out of ‘respect’ for the culture, but also out of fear of being labelled as racist” (Erica Burman et al., 2004: 347).

Ethnic minority women suffer a lack of protection within their community, and are often isolated from mainstream society, and left unprotected because of racism perpetrated by the police or police fears of being labelled racist (Maynard & Winn, 1997: 181). Stakeholders

within public institutions are conscious of their anxiety of being found to be racist (Erica Burman, 2003: 298). As Erica Burman (2003) argues:

Stakeholders “worry about being culturally inappropriate or (eliciting accusations of being) racist if they question or criticize particular practices occurring within minoritised groups... this includes what are perceived to be ‘culturally specific’ practices” (298).

Erica Burman (2003) contends ‘race anxiety’ is “a form of obsessional undoing of the effort to challenge racism” (293). Through the effort to avoid being racist, the opposite occurs (Erica Burman, 2003: 301). The failure to challenge assumptions about culture feeds racist stereotypes that other communities condone violence or are oppressive to women (Erica Burman, 2003: 301). ‘Race anxiety’ took the form of silence on the part of white workers when dealing with abuse in ethnic minority relationships (Erica Burman, 2003: 301). As one participant said during an interview conducted by a research study of Batsleer, Chantler, and Burman (2003), he “did not want to be seen as a colonial bastard” (Community Mental Health Worker, 3.6.5). Workers demonstrated helplessness as they presented as insufficiently culturally equipped to work with minority women, and thus were fearful of being culturally inappropriate or racist if questioning or criticising particular cultural practices (Erica Burman, 2005: 536).

While it may appear safer for stakeholders to remain silent to avoid contentious issues, for ethnic minorities silence from stakeholders can cause frustration and danger (Batsleer et al., 2003: 106). Race anxiety resulted in cultural issues being afforded greater priority by service providers rather than gender-based violence, which led to women being denied the support and protection they required (Erica Burman, 2005: 538). Ignoring violence amongst cultural groups led to women’s rights groups complaining that stakeholders were failing to act because of exaggerated respect for cultural difference resulting in inverted racism (Dustin & Phillips, 2008: 408).

Dustin (2010) asks why violence against American and European women is *not* seen as cultural but instead an aberration of the individual man, while violence against African, Arab and Asian women is viewed as intrinsic to their culture and identity, which in turn is linked to racism (9). The behaviour of cultural groups is perceived as more culturally determined than that of the dominant culture (Sokoloff & Dupont, 2005). The powerful West is seen as having no culture but the universal culture of civilization (Sokoloff & Dupont, 2005). Black and Asian activists have campaigned for honour killings and forced marriage to be viewed as

forms of violence not culturally specific practices (Erica Burman, 2005: 537). This could prevent the link between gender-based violence and culture. Scholars struggle to achieve a balance between the impact of culture and tradition on violence and how patriarchy operates differently in diverse cultures (Sokoloff & Dupont, 2005). Rather than viewing FGM as culture, scholars argue that it should be viewed as a patriarchal traditional custom in the context of colonialism and economic exploitation of marginalised communities (Sokoloff & Dupont, 2005).

Conclusion

Theories of feminism, international human rights, cultural relativism and racism have been examined within this chapter. Research focusing on FGM raises questions of gender, race, culture and class, which are key to understanding FGM-performing communities and stakeholder's attitudes and beliefs towards the practice and the law. An overview of relevant theories serves as a foundation to the analysis of interview data within the empirical chapters of this thesis. This thesis aims to address why the practice persists when it is a criminal offence. Given the diverse background of participants, women and stakeholders inevitably have different attitudes and beliefs towards FGM. I therefore approached the literature review as an opportunity to explore tensions between vocal opponents of FGM, critics of anti-FGM rhetoric and supporters of FGM. Rather than siding with one perspective, the purpose of this chapter was to explore competing views towards FGM that are will emerge in the empirical chapters.

This chapter commenced by outlining the key debates about FGM amongst Western feminists and African women with the former describing FGM as an oppressive practice, which controls women's sexuality and the latter viewing FGM as a source of power and identity for women. Their divergent conceptualisation of FGM is central to understanding the polarised views of women and stakeholders towards the practice. I draw on key themes of agency, autonomy and oppression within the empirical chapters where I interpret women's experiences and understandings of 'choice' and 'consent' to FGM.

I then moved onto exploring FGM from the theoretical position of cultural relativism and international human rights. Cultural relativism regards FGM as a legitimate cultural/traditional practice and criminalisation as a product of ethnocentric imperialism, while human rights proponents view FGM as a fundamental violation of a woman's and girl's right to bodily integrity. Both approaches resonate with the interviewees in the empirical

chapters. Cultural relativism is a key theme within FGM-performing communities who attempt to justify FGM as ‘cultural’ practice, while understandings of FGM from an international human rights perspective dominate stakeholders’ attitudes towards FGM and women who side with the anti-FGM lobby.

The final theme explored in this chapter was the link between FGM, race, racism and Islamophobia. The literature shows that ethnic minority women experienced racial discrimination when seeking support for domestic violence from service providers and stakeholders struggled to support ethnic minority women due to race anxieties and lack of cultural training. The empirical chapters explore whether similar race dynamics exist in a context of service providers’ support for FGM. As there is no literature exploring whether FGM and anti-FGM rhetoric has given rise to Islamophobia, I drew on research examining the relationship between the Islamic veil and Islamophobia. The literature and empirical evidence show that practices directly associated with Islam, such as the wearing of Islamic clothing, have given rise to Islamophobia and an anti-immigration agenda. Muslim women resisted public narratives of the Islamic veil as oppressive to women and instead adopted the wearing of the Islamic veil to subvert hegemonic understandings of the practice and show resistance. The empirical chapters explore whether women attempt to resist dominant narratives of FGM as oppressive by reinforcing the practice. This could assist in explaining why the practice persists when it is prohibited.

Chapter Three:

Methodology

Introduction

This chapter outlines the empirical method applied in this thesis and the process of collecting, interpreting and analysing data. The empirical data consists of qualitative semi-structured interviews with 79 participants and two focus groups (each with 11 participants). Appendix I provides information pertaining to the interviewees and interview process. The participants included 13 women from FGM-performing backgrounds, two men from performing communities and 64 stakeholders working in FGM related areas. I also conducted two focus groups, each comprised of 11 women of Somali origin⁷⁸.

This thesis provides an insight into the practice of FGM and anti-FGM legislation from two divergent perspectives: FGM-performing communities and stakeholders. The purpose of interviewing two different groups of people is to answer the core research question, which is, why does FGM persist in a context in which it is criminalised. To answer this research question it is important to understand women's experiences of FGM and criminalisation and the attitudes of stakeholders towards anti-FGM laws. This study provides a valuable contribution to the literature addressing FGM and anti-FGM legislation in England.

The chapter commences with a discussion of the aims of the study and the research questions, which frame the methodological approach. A significant part of this chapter is dedicated to reflexivity and ethics, and the potential and challenges of this methodological approach. The empirical method is explored in depth. This includes the sample of participants, the recruitment approach adopted, the interviewing process, data analysis, the interpretation of data and the dissemination of data.

Aims of the Empirical Research

⁷⁸ All participants were habitually resident in England, which means their primary residence at the time of the interviews was England.

The central aim of this empirical study is to examine why FGM persists in England despite the criminalisation of the practice in 1985. This involves exploring the potential and limitations of social change through the law. This study focuses on the practice of FGM and the law's response to FGM from the experience of FGM-performing communities and stakeholders responsible for designing and enforcing legislation and working with affected communities. I have also set out to investigate how and the extent to which the law has impacted upon communities' and stakeholders' behaviour, attitudes and beliefs towards FGM. While there have been studies⁷⁹ of FGM internationally – partly because FGM is considered a cultural and traditional practice prevalent abroad – scant attention has been paid to responding to FGM in England.

The increase of the practice in England following the arrival of women and girls from FGM-performing countries has received relatively little critical academic analysis (Mohammad, 2005: 132). While there has been public critique of the lack of prosecutions for FGM (Bindel, 2014), as well as scholarly attention directed at the design of FGM legislation and enforcement mechanisms, notably through cross-European legislative analyses (Leye, 2005; Leye & Deblonde, 2004; Leye et al., 2007; Leye & Sabbe, 2009), much less effort has been invested in listening to the voices of women from FGM-performing communities whose lives these policies and practices impact upon and to the views of those responsible for designing and enforcing FGM legislation.

Women's accounts of FGM have been the focus of a few small studies. However, this body of work has concentrated almost exclusively on women affected by FGM and the majority of studies are small⁸⁰. Moreover, the attitudes and beliefs of FGM-performing communities towards anti-FGM legislation have not been examined empirically and neither have the views of stakeholders who work directly with women. The primary consideration of this empirical study is to explore why FGM persists in a context in which it is criminalised. This involves exploring the attitudes and beliefs of women and stakeholders towards the practice, the effectiveness of anti-FGM laws and the impact of the laws upon the lives of communities. To

⁷⁹ The studies are usually anthropological. For anthropological perspectives see El Dareer, 1982, Boddy, 1982, 1989; Shell-Duncan, 2000; Ahmadu, 2000; Gruenbaum, 2000; Gosselin, 2000; Hernlund, 2000.

⁸⁰ For recent empirical work about FGM in the UK see: Norman, Hemmings, Hussein, and Otoo-Oyortey (2009) where 10 volunteers carried out three interviews with three friends from FGM-performing communities, resulting in nine interviews each and an edited book by Bradley (2011), which includes the stories of a small sample of women interview participants.

this end, I examined the following questions, each of which comprise one of the empirical chapters of this thesis:

4. What are the motivations for continuing the practice of FGM?
5. What are women's and stakeholders' attitudes and beliefs towards the criminalisation of FGM and what impact have anti-FGM laws had on the dynamics of the practice?
6. What are the barriers to anti-FGM laws deterring and eliminating FGM?

Methodological Framework

My interest in women's and stakeholders' experiences and accounts of FGM and the law, led me to consider a qualitative approach of semi-structured individual interviews and focus groups. Largely as a result of my own background⁸¹ I was keen to interview women and stakeholders themselves. I chose semi-structured and open-ended interviews and focus groups to give participants the power to define the research agenda and the issues they wanted to talk about. This contrasts with structured interview questions or surveys which give a perception that participants are expected to disclose personal information that could leave participants feeling exposed (Oakley & Roberts, 1997). Like Raymond, I favour "the 'unstructured research interview' employing open-ended questions," because it "maximizes discovery and description" (1979: 16).

Interviews and focus groups are an important contrast to quantitative methods, which do not always allow for the free interaction between researcher and participant and social researchers that is required for an exploratory study. Having explored a feminist theoretical framework within the literature review of this thesis, my decision to undertake qualitative interviews was also influenced by feminist theory. Women and girls often have different experiences *because* of their gender. Feminist social research studies have "powerful liberating effects" by bringing forth "a wealth of previously untold stories" (DeVault & Gross, 2007: 173) – those of marginalised ethnic minority women who have experienced FGM. The women interviewed were from ethnic minority backgrounds. I reminded myself throughout the interview process that women might have different experiences *because* of their race. Women's experiences of sexism and racism are likely to impact upon their attitudes and beliefs towards FGM and anti-FGM laws.

⁸¹ I practice as a barrister specialising in family and immigration law working with women at risk of FGM and women who have undergone FGM. I spend considerable time listening to the stories of women and conveying them to judges in a court arena.

While feminist research shares some common goals and visions, there is no single feminist epistemology or methodology (Hesse-Biber, 2012). Instead, feminist qualitative research tends to comprise the following core tenets: ensuring experiences from women's lives are heard (Finch, 1993); an ethic of commitment and egalitarianism through openness and engagement (Oakley & Roberts, 1997); the need to alter and critique "the power configurations in the development of knowledge" and the need to critically reflect on research processes because most of the knowledge and the research processes in our society have been produced by men (Spender, 1981: 8); "strong reflexivity throughout the research process" enabling "feminist researchers to improve the objectivity of research" (Hesse-Biber, 2012: 10); and woman-to-woman interviewing using categories that represent women's lives rather than categories that reflect men's activities or social science terminology (Reinharz, 1992).

Feminist research aims to give women of all racial backgrounds a voice and a platform that embraces the diversity of women's experiences. Like Reinharz (1992) states, "interviewing offers researchers access to people's ideas, thoughts and memories in their own words rather than in the words of the researcher" (1992: 19). This research is feminist to the extent that the central aim of the interviews is to put women's voices at the forefront of this research. This approach places women's lives and experiences on centre stage, challenging our understanding of the social world and also showing how those arrangements tend to privilege and accommodate the needs and aspirations of men (Conaghan, 2000).

The Impact of Reflexivity, Intersectionality and Ethics upon this Study

I questioned whether consideration of FGM could be done fairly by a white woman, or if black women are in a better position to address the topic. A white woman would again be given public space to address FGM. I am only able to undertake this research because black women have agreed to speak with me about FGM and because black women have, for many years, developed critiques of mainstream feminist scholarship⁸². My thesis is an attempt to apply their analytical insights concerning the limits of feminist legal theory in the context of women's lives. Like Kline (1989), I believe it is important that white women take responsibility and identify our racism and work to eliminate it, rather than leaving the work to

⁸² See Obiora (1997), Obermeyer (2005), Obermeyer (1999), Ahmadu (2000), Gunning (1991).

black women. In fact, this has been a critique made by many black women (Hooks, 1981). I am not attempting to speak for black women. Rather, my intention is to continue the development of feminist approaches to law by applying it to issues that affect black women's bodies, namely FGM, which have previously been marginalised.

There has been evidence of growing reflexivity in social research in the form of researchers' greater awareness and acknowledgement of the impact of their cultural, political and social context on the construction of knowledge (Bryman, 2012). I found it deeply important to maintain reflexive awareness during interviews in particular, as they are never simple encounters, instead they are "embedded in and shaped by cultural constructions of similarity and difference" between the researcher and the participant (DeVault & Gross, 2007: 181)⁸³. According to Edwards (1990) reflexivity means:

"The researcher's effect upon the actual process of the research, her class, race, sex, assumptions and beliefs, should be explicated in terms of its effect upon the research and upon analysis" (1990: 479-480).

Given the androcentric and ethnocentric biases that so often mark research conducted, researchers engage in reflexivity, accounting for their personal effect on the research project (DeVault & Gross, 2007). I differed from the women I interviewed in many respects, since I am a white, middle class woman and I was age 26-27 when I conducted the fieldwork for this dissertation. There is a significant divide between my background and the backgrounds of the participants, who were black women from working class and middle class backgrounds. Race, gender, class, age, education and profession are all key differences between the participants and myself.

Race⁸⁴ emerged as a theme of differing significance during the interviews. Race is not biologically given or a fixed social category, but socially constructed (Rhodes, 1994). Given

⁸³ According to Chase (1995), constructions of differences and similarities impact on every aspect of the interview process from designing questions, deciding not to ask certain questions, the ease or difficulties of recruiting participants, the relationship with the participant and the lenses researchers produce and analyse data (Chase, 1995 in DeVault, 2007).

⁸⁴ Rhodes (1994) contends racial matching of interviewer and participant risks marginalisation of black researchers and, as a methodological approach, its assumption of a single truth is open to challenge.

the racial structural divisions between me and the participants, I was wary of overlooking the “broader politics of the “personal”; that is the institutions, processes and interactions” shaping black women’s experiences (DeVault & Gross, 2007: 177). Indeed, race is an important aspect of black women’s identities in their experience of the world and their interactions between themselves and stakeholders. Stakeholders’ race also contrasted with women from FGM-performing communities’ race, as they are mainly white, which impacts upon their experience of the world, FGM and the law. Stakeholders are unlikely to have experienced racism and structural inequalities and have dissimilar social worlds to the women interviewed, thus their attitudes are going to differ to women’s beliefs.

Following Edwards (1990) suggestion, I addressed racial identities explicitly by highlighting the difference in social location between me and the participant. For example, I would start the interview by openly stating my limitations in researching FGM, one of which is that I am not from an FGM-performing community and have not experienced the practice, but I am interviewing women because I want to learn, understand and listen to their voices. My status as an outsider, unfamiliar with the cultural practices, religion, family and community traditions, gave participants the status of experts of their social worlds, as they explained every aspect of their lives, sometimes in intricate detail (Miller & Barry, 2004). Furthermore, the ‘stranger value’ allowed participants to vent a sense of injustice and anger, which they felt unable to express to women and men from their community for fear of discussing a taboo, expressing opinions they assumed would be different, therefore risking social ostracisation⁸⁵ (Rhodes, 1994). Indeed, women did not need to feel concerned that they could be recognised or traced, as I was an outsider from their community (Erica Burman et al., 2004: 341). In addition, my outsider status meant some women spoke to me as a representative of white people and treated the research as a mode of conveying their views about FGM to a wider (white) audience (Rhodes, 1994). Gunning (1991) recommended a method for feminist “outsiders” requiring them to criticise their own, often invisible culture-based practices from the perspective of the “other”. Taking on board this approach, I also critique FGCS. Indeed, Lewis (2003, 1995) argued that engagement in self-critical dialogue across borders is necessary for any international approach to human rights.

Historically, white women have been unable to hear black women’s words, or to maintain dialogue with black women (Lorde, 1984). Feminists urged scholars to recognise the various forms of violence and oppression that characterise the lives of black women and locate

⁸⁵ Some participants remarked that it was easier to speak to me as a white woman than to black women about FGM.

authority and truth in the realities of black women's lives rather than the 'wisdom' of the Euro- and androcentric disciplines (DeVault & Gross, 2007: 177). Anti-racist feminists, particularly black feminists,⁸⁶ suggest that analyses of black women are often problematic because they reinforce stereotypes and assumptions about black women, for example that black women are portrayed as victims of culture⁸⁷ (DeVault & Gross, 2007). According to Narayan (1997), these stances erase the work and agency of women in transforming their social worlds. Following the suggestions of DeVault and Gross (2007), I attempted to locate women's agency in acts of resistance and accommodators of FGM rather than portraying them as victims (Meyers, 2000).

In reviewing the literature produced by feminists on white women interviewing black women, Edwards (1990) argues that in spite of their differences, there are ways in which their gender may unite black and white women. Oakley (1981) argued researchers should develop ways of conceptualising the interview as an encounter between women with common interests, who would share knowledge (DeVault & Gross, 2007). Finch spoke of the special nature of woman-to-woman interviews "because both parties share a subordinate structural position" (1984:76). In my view, my position as a woman assisted in discussion about sexual experiences after having been cut and women responded in a frank, honest and open manner. However, I was conscious of the "exploitative potential in the easily established trust between women, which makes women especially vulnerable as subjects of research" (Finch, 1993: 81). I was concerned about exposing women to trauma as they divulged their personal narratives. As a result, I avoided asking women directly about *their own* story of FGM, instead I asked them about FGM more broadly. All of the women were, in my view, open in discussing their personal experiences, often in detail.

It is important to note that there is a fundamental challenge for feminist researchers when engaging in woman-to-woman interviewing: scholars need to be wary of treating gender as a homogenous, unified variable thereby neglecting that women are diversely situated in culture, race and class (DeVault & Gross, 2007: 175). The criticism of essentialism was a call for a more inclusive feminist politics that seeks to engage with diversity among women (Conaghan, 2000: 371). Though feminism must and does start out from the assumption that sex/gender has a general significance, it must avoid essentialising 'woman' instead recognising the interaction between other axes of social differentiation such as race, socio-economic class, age and sexual orientation (Lacey, 1998: 13). As Kaplan (1994) stated, we

⁸⁶ See, Bannerjii, 1995; Collins 2000; Mohanty, 2003; Narayan, 1997.

⁸⁷ The same assumptions used to justify imperialism and colonisation.

need to be cognizant of the differences and similarities that exist between women. However to a large extent feminism continues to grapple with this tension. Feminism owes much of its history to the political organising of marginalised groups of women including women of colour, which was “instrumental in dismantling the idea that all women are the same” (DeVault & Gross, 2007: 175). My approach to research seeks to ensure that women’s subjective experiences are uniquely located within intersections of race, culture, class and history. Indeed, some women described their own experiences of race and gender discrimination in England. As a woman working in law, I pay attention to the particularities of women’s lives, which inform the analysis of women’s situations and the development of legislative reform proposals (Conaghan, 2000: 371).

A further gap in the literature on feminist methodology relates to the ways in which gender, race, social class, education and profession of participants intersect with those of the researcher (Phoenix, 1994). Class, age, education and profession were also key distinctions between my background and the participants’ backgrounds. I introduced myself as a PhD candidate and most women referred to me as a student. My youthful appearance and student status helped relax participants into friendly conversation and it meant I was perceived as young and eager to listen and understand their social worlds. My middle class and educated background could have been intimidating for participants and therefore a barrier to trust, however my background was mitigated by my ‘outside’ status from their community, which meant I relied on participants as experts of their social world to guide and structure the interview.

Women represented several social classes: socioeconomically disadvantaged, working class and middle class. Discussions of class were evident in the interviews, as they described how their life conditions were manifested in their educational and socioeconomic background and one’s position in the community, presenting a complex picture (Johnson-Bailey, 1999). All participants knew and had experienced, either personally or through their communities, that poverty was a reality in the lives of many black people and many described their experiences of war having fled Somalia and Sudan as asylum seekers and then living in the UK as refugees (Johnson-Bailey, 1999). Women described their early experiences of poverty and deprivation and their parents and grandparents’ lack of education, as explanations for performing FGM.

Sample of Interview Participants

Fieldwork lasted a total of 11 months, from October 2014 to September 2015, and took place across England. I interviewed 79 participants and undertook two focus groups, each with 11 women. To determine who I should interview for the research, I mapped out 10 groups of people. Appendix I provides information relating to the participants, including their origin and stakeholders' organisations and roles. Participant groups include women from FGM-performing communities, stakeholders working closely with FGM-performing communities (i.e. NGO workers) and stakeholders involved in designing and enforcing FGM legislation (i.e. Members of Parliament). As these groups of stakeholders have direct experience of FGM, I assumed they would shed light on the impact that the law has had upon the prevalence of the practice, thus assisting in answering the research question of why FGM persists despite criminalisation.

Some of the women interviewed from FGM-performing communities were also stakeholders, as they held jobs such as teachers, social workers or midwives. Where women held jobs that are relevant to this research study I identified their occupation within the description of the interview participant (see Appendix I). However, their attitudes and beliefs as women from FGM-performing communities were considered the most important factor when interviewed because they could share insights into a closed community. Women who were stakeholders often held a nuanced view, as they were insiders in their community and had knowledge of how FGM is perceived by outsiders. Where relevant, women were questioned about their professional experience.

I also undertook two focus groups, each with 11 women, the majority of whom disclosed that they had undergone FGM. All women participants originated from Somalia. The sample was determined by the NGOs that organised the focus groups and recruited participants.

Prior to commencing the interviews I intended to interview at least 80 people and conduct two focus groups for the following reasons: first, there are no large-scale empirical research studies of FGM in England, therefore there is a lacuna in the literature that I intend to contribute to filling. Second, conducting a substantial number of interviews assists in drawing upon reliable themes. Third, conducting around 80 interviews was realistic within an 11-month timeframe.

Sample, Recruitment and Interviewing Stakeholders

As noted in Appendix I, there are two groups of participants, namely women from FGM-performing communities and stakeholders. The groups of stakeholders that were interviewed including law enforcement agents, civil servants, Members of Parliament, Members of the House of Lords, NGO workers, medical stakeholders, social workers, teachers and religious leaders. The gender of the stakeholders is outlined in Appendix I. Their gender is important as this thesis applies an intersectional theoretical perspective. This section of the chapter reflects on how I accessed interview participants from each group and how I went about interviewing them.

Law Enforcement Agents

As there has not been one successful prosecution for FGM, a pivotal aspect of this research project was to critically evaluate the barriers to enforcing anti-FGM legislation. Addressing this issue assists in exploring the core research question of why FGM persists despite it being criminalised. To answer this research question it was imperative to interview law enforcement agents responsible for enforcing legislation, including lawyers, police officers and Crown Prosecution Service (CPS) workers. As a barrister specialising in family and immigration law, accessing barristers and solicitors was straightforward. I knew some of the lawyers I interviewed personally because we worked together on various FGM initiatives. Other lawyers interviewed were put in contact with me through colleagues.⁸⁸

I contacted the CPS through their official website but I received an email response declining to participate in the project due to insufficient time and resources to dedicate to external research. I eventually gained access to employees at the CPS through attendance at FGM conferences. Participants were reluctant to put me in contact with other employees at the CPS

⁸⁸ I explore reflexivity later in the methodology, however I want to identify my background and the impact of this upon the thesis. As addressed in introduction, I practice as a barrister, which involves working on cases of FGM and assisting with research initiatives, including a report written by the Bar Human Rights Committee (2014), which aims to work towards the elimination of the practice. While my background is working towards ending FGM, this thesis shows a broad cross-section of attitudes towards the practice including those that defend FGM to allow women's voices to be heard. It is important to listen to all sides of the debate on FGM in order to understand why the practice persists and why the law appears to have been ineffective in decreasing FGM.

due to confidentiality concerns and they pressed upon me the importance of maintaining anonymity.

It was challenging to gain access to police officers. I contacted Project Azure, which is a branch of the Metropolitan Police Service specially aimed at tackling FGM, however they declined to participate in the project due to concerns about confidentiality and anonymity. NGOs put me in contact with police officers that had experience of cases of FGM and they kindly agreed to be interviewed.

Members of Parliament and Members of the House of Lords

Members of Parliament and Members of the House of Lords comprised one group of participants because they played a valuable role in designing FGM legislation. They provided an understanding of the motivation for and interpretation of the law. I compiled a list of Members of the House of Lords and Members of Parliament who had been instrumental in introducing and amending FGM legislation⁸⁹. I then sent a letter and/or email informing them about the research project and asking them to participate. If they did not respond within one week, I contacted them by telephone and/or email. Every member of the House of Lords I contacted agreed to be interviewed⁹⁰. Several Members of Parliament declined to be interviewed due to time restraints of the upcoming general election on 7 May 2015.

Civil Servants

I used a snowball sampling technique and gained access to civil servants through other interviewees. An NGO put me in contact with a civil servant at the Department of International Development who agreed to take part in the project. After the interview, the participant sent an email to the Department for Education introducing me to a civil servant

⁸⁹ I did this by reviewing Hansard – the official reports of the proceedings of the House of Commons and the House of Lords to see who took part in debates on FGM. Hansard is available online: <http://www.parliament.uk/business/publications/hansard/> [Accessed 23.04.2017].

⁹⁰ A Member of the House of Lords contacted the House of Lords library on my behalf and asked the library to summarise FGM legislative initiatives debated in the 1980s. Another Member of the House of Lords printed the Hansard debates in the 1980s and posted them to me.

who then took part in the research project. After the interview, the participant emailed the Department of Health and a civil servant agreed to take part in the research project. Unfortunately the civil servant declined to put me in contact with the Ministry of Justice due to stringent confidentiality concerns. As a result, interviews with civil servants ceased at the Department of Health stage.

NGOs Working with FGM-Performing Communities

NGOs comprised one of the groups of participants because they are informed about the law and work directly with FGM-performing communities. They are in a key position to identify the impact of the law upon women's attitudes and beliefs towards FGM. I compiled a list of NGOs running community grassroots programmes for women affected by FGM in England. I emailed the NGOs and introduced my proposed research and invited them to participate. The majority responded to set up a time and date for the interview. When I did not receive a response within one week I telephoned each NGO to reiterate my request to the relevant person dealing with the FGM programme⁹¹. Some declined to participate due to funding shortages.

Medical Practitioners

The most likely profession to encounter women affected by FGM is the medical profession. They may come in contact with women when they are pregnant or give birth, or when they experience health consequences related to FGM (Gordon, 2005). I contacted NHS' specialist services for FGM by email to introduce my proposed research and invite the specialist health provider to participate⁹². I received a positive response from doctors, midwives and nurses, partly because they were keen to generate awareness of the specialist medical work they perform and to highlight the importance of investing resources to train more medical stakeholders about FGM. During the interviews, medical practitioners referred to the medical

⁹¹ Due to issues of confidentiality and anonymity I cannot disclose which NGOs I contacted. The majority agreed to take part in the study. Those who did not take part in the project either did not return my calls or respond to my emails, or they explained they did not have the resources to take part in the research project.

⁹² For a list of NHS Specialist Services for FGM see:

<http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%2014%20FINAL.pdf>
[Accessed 23.04.2017].

standards set by the General Medical Council (GMC). Given that the GMC was mentioned frequently, I contacted them and asked if they would participate in the research project and they agreed.

As FGCS emerged as a dominant theme of the interviews, I decided to interview cosmetic surgeons about the two practices of FGCS and FGM, the overlap with FGM, the surgeons' response to requests for FGM under the guise of FGCS, the types of surgery and the legality of FGCS. I met a cosmetic surgeon who performs FGCS at an FGM conference. The cosmetic surgeon agreed to be interviewed for the research and he put me in contact with other cosmetic surgeons to interview for the research, all of whom were men.

Social Workers

Social workers are responsible for safeguarding children from child abuse, thus I was keen to interview them about their child protection duties in situations where a child has been cut and where a child is at risk of being cut. I met one social worker at an African cultural event that agreed to be interviewed and she put me in contact with another social worker that I also interviewed. I accessed the third social worker through a social work organisation that I contacted. Overall, it was challenging to contact social workers because they do not have a public profile due to the sensitive and confidential nature of their work.

Teachers

Aside from medical stakeholders, teachers are the second most likely group of stakeholders to encounter girls who have been affected by FGM due to the close relationship teachers have with pupils. As a result, I was keen to gain an insight into teachers' responses to tackling FGM, in particular whether they used the law as an advocacy tool when speaking with parents about the practice. I contacted two renowned teachers who are anti-FGM activists by sending an email outlining my research project and enquiring as to whether they would be open to being interviewed. They both agreed to be interviewed and one participant put me in contact with three teachers from other schools that also agreed to be interviewed.

Religious Leaders

During interviews, NGO workers consistently reiterated the important role of Imams in raising awareness about FGM and safeguarding children, thus I attempted to interview Imams

about their role in the community in relation to FGM. I contacted 10 mosques in my local area by email or telephone informing them about my research project and inviting the Imam to participate. They all declined to participate due to lack of time and resources. I contacted two mosques in Cambridge and one Imam agreed to participate, partly because he is an academic and identified with the difficulties of recruiting interview participants for academic research purposes.

The Challenges of Interviewing Stakeholders

I chose to interview stakeholders that work with FGM-performing communities and that are responsible for designing and enforcing FGM legislation. I wanted to examine stakeholders' attitudes as to why FGM persists in a context in which it is criminalised. There have been very few empirical studies in this field and significant changes have taken place in the legislative framework governing FGM, notably the Female Genital Mutilation Act 2003 and the Serious Crime Act 2015. I hoped to identify perceptions of changes in behaviours, attitudes and beliefs towards FGM as a result of the legislative changes over the years.

I conducted 64 interviews with stakeholders. All interviews were conducted in English. The participants were selected to reflect the broad range of stakeholder backgrounds of those who work with FGM-performing communities. I tried to select individuals who had direct experience of working with girls and women at the grassroots level. In addition, I selected individuals who were responsible for designing FGM legislation and enforcing the law. The role of stakeholders interviewed is illustrated in Appendix I. They came from a variety of stakeholder backgrounds – including the medical profession, law enforcement agents, NGO workers, politics, teachers, civil servants, social workers and an Imam. The stakeholders' experience of working with FGM communities and designing and enforcing FGM legislation ranged from one to 50 years.

Interviews with stakeholders lasted between 20 and 90 minutes and most were conducted by telephone or in person in private rooms at the participant's workplace or in a café near the participant's workplace. Prior to the interview, I read the consent form and stakeholders agreed to the terms. All of the interviews were tape-recorded and transcribed in full. The semi-structured interview questions were designed to encourage conversation with stakeholders about the practice of FGM: who, what, where, when and why it is performed, experiences of working with communities, their perceptions of legal responses to the practice and their views about how the law can be used to end FGM. Interviews with stakeholders led

to a snowball effect, with stakeholders introducing me to other stakeholders and members of FGM-performing communities who I later interviewed.

All stakeholders signed the same consent form as the women interviewed. The consent form addressed concerns about disclosure, stating that if the participant identified that a person or child is at risk of FGM or another criminal offence, I would report this information to the police. No one made any disclosures. However, on occasion stakeholders' behaviour, attitudes and beliefs conflicted with FGM legislation and child safeguarding policies. Some stakeholders admitted that they did not follow the law and child safeguarding policies and they knew of other stakeholders who also failed to do so⁹³. My role as the interviewer did not involve giving stakeholders legal training or highlighting inconsistencies between their behaviour, attitudes and beliefs towards FGM and FGM legislation, nor did it involve acting as an informant⁹⁴. Instead I listened to the stakeholders' responses carefully and their responses shed light on several reasons for the non-enforcement of FGM legislation.

Several advantages ensued from the fact that I am a young female student⁹⁵. Stakeholders appeared to assume that I had little understanding of FGM and the law, as an unthreatening 'student,' stakeholders shared more information with me than I initially expected. On the other hand, a few stakeholders⁹⁶ attempted to take advantage of my identity as a woman and perceived youth by patronising me and reaffirming their authority by trying to control the

⁹³ Some stakeholders told me that they had a clear divide between their views as professionals and their personal views, some stakeholders said they were compelled to say FGM is child abuse, but personally they believed FGM is a legitimate social, cultural and in some cases religious practice.

⁹⁴ If I contradicted stakeholders it would have changed the dynamic of the interview relationship, with stakeholders fearing that I would disclose their personal views.

⁹⁵ I introduced myself as a PhD candidate but was repeatedly referred to by stakeholders as a student. When I was asked specifically about my background and interest in FGM, I explained that I am also a barrister specialising in family and immigration law and that I have worked on cases involving FGM. Once the participant was aware I was a barrister, they did not attempt to patronise me and instead referred to my experience throughout the interview, i.e. "as you would know as a barrister..." or "you would know better than me given your experience in law." Given the social and legal status conferred to barristers I was reluctant to mention my background unless probed, as I did not want participants to fear disclosing their views for fear of repercussions.

⁹⁶ Mainly medical stakeholders.

interview. For example, one doctor informed me that the question I asked did not make sense and he went on to rewording the question and then set about answering his own question⁹⁷. I refused to engage in power dynamics. Instead I covered all of the topics I sought to cover and then ended the interview.

Sample, Recruitment and the Challenges of Interviewing Women

FGM-performing community members formed a crucial group of participants, as they shed light on who performs FGM, why FGM is performed, when FGM is performed and how, as well as outlining whether the law has changed their behaviour, attitudes and beliefs towards the practice. It was important to understand these issues in order to answer the research question of why FGM persists despite its criminalisation.

As I am not from an FGM-performing community I was initially reliant on accessing members of the community through NGOs. Once in contact with women from FGM-performing communities, snowball sampling took effect with women giving me the contact details of other women to interview. I conducted two focus groups with 11 women in each, which were organised by two NGOs. The NGOs agreed to organise the focus groups because it formed anti-FGM advocacy work, which comprised part of their projects on FGM and helped raise awareness about FGM through sharing experiences and stories. Not all NGO workers were anti-FGM advocates and some defended the practice. The women they invited to the focus groups came from a broad cross-section of the community, from three different generations with varied educational backgrounds and diverse views on the elimination of FGM.

There is the possibility of selection bias, as the participant women are likely to be known the NGOs and thus more likely to support anti-FGM work. However, the findings show that many women in the focus group were vocal proponents of FGM. Furthermore, one-to-one interviews were conducted in English, which is an additional selection bias. There was no other way for me to obtain a representative and randomised sample of participants. Findings

⁹⁷ Another medical stakeholder asked me whether I understood a woman's anatomy and then laughed to herself when I explained that I did. After I asked another question, the same stakeholder asked me the question back, which I answered. She then cheered and said, "well done, you got there in the end."

from the empirical research should be considered in light of possible selection biases, as such the research can only be described as exploratory.

Men are an important group of participants because they are one of the main reasons FGM is performed⁹⁸. I found it extraordinarily difficult to access men. NGOs did not know of any men who would take part in the research, partly because the FGM programmes they run are for women⁹⁹. Women from communities did not know of men who would be amenable to being interviewed because they had not discussed FGM with men or if they had talked about FGM, the conversation had been uncomfortable. I interviewed two men for the research project. I met one man at an FGM conference and I met the other man through an African cultural community event. Neither was able to put me in contact with other men to interview.

Ethical Concerns when Interviewing Women

I did not interview girls under the age of 18 because the ethics committee at the Department of Sociology advised against this. Interviewing minors would have raised the following substantive ethical concerns that could have detracted from my research project: can a minor consent to the interview or should a parent and/or guardian consent on the child's behalf¹⁰⁰, if the child disclosed that she had been cut or I considered on the facts that the child was at risk of being cut, I would have an obligation to report this information to the police which could cause the child further harm and have legal implications for the parent¹⁰¹; and I would have to consider the trauma to the child of divulging personal information to a stranger for research

⁹⁸ Dorkenoo (1994) contends that the practice of FGM is strongly linked to virginity, chastity and fidelity, which are prerequisites to marriage.

⁹⁹ I contacted one NGO to ask if I could interview the manager who is a man from an FGM-performing community. I was informed that he did not feel comfortable discussing FGM with a woman, as it is "women's business,"

¹⁰⁰ The ethical guidance of British Sociological Association (2002) states at paragraph 30 that "the consent of the child should be sought in addition to that of the parent", although there is no legal mandate or requirement to do so (Sturges & Hanrahan, 2004)

¹⁰¹ Paragraph 25 of the ethical guidance of British Sociological Association (2002) states that guarantees of confidentiality and anonymity given to research participants can be overridden when it comes to the abuse of children.

purposes¹⁰². Considering the ethical concerns I decided on balance not to interview minors. In practice, this meant that some girls were denied the opportunity to participate in the research.

A prevailing concern was that a participant might disclose that an individual is at risk of being subject to FGM. If a woman disclosed that a child or woman was at risk of being cut,¹⁰³ I would have had an obligation to report this information to the police according to the ethical guidance of the British Sociological Association (2002), but not the law¹⁰⁴. To make this clear to the participants, the consent form stated: *If during the interview a person or child is identified as being at risk of female genital mutilation or at risk of another criminal offence I will report this information to the police.* The participant then had to tick a box to confirm they understand this. No one made any disclosures.

Running Focus Groups

Two NGOs agreed to host one focus group each¹⁰⁵. One NGO was based in London and the other was located in Leicester. The NGOs recruited participants and provided an interpreter who spoke Somali and worked at the NGO¹⁰⁶. There were 11 participants in each focus group and all participants were of Somali origin because the charities worked with the Somali

¹⁰² Risks to the child include psychological harm from discussing distressing topics, harms and wrongs if confidentiality is breached and violations of autonomy if the informed consent process is flawed, all of which could compound the harm arising from child abuse (McCarry, 2005)

¹⁰³ FGM is a criminal offence regardless of the age of the girl or woman.

¹⁰⁴ At the time of the interviews, the Serious Crime Bill was introduced into the Houses of Parliament, which intended to make the reporting of FGM for regulated professions mandatory (i.e. medical professionals, teachers and social workers). However, I do not fall within any of the regulated professions and therefore this duty would not have applied to me even if the law had been introduced when I conducted the interviews.

¹⁰⁵ They agreed to host a focus group because it was an opportunity for community members to discuss FGM with other women in a safe and supportive environment. For confidentiality and anonymous purposes, the NGOs are not identified.

¹⁰⁶ The NGO in Leicester did not ask me to reimburse participants for their travel costs. However, when I asked if it were possible to organise a second focus group they declined due to limited resources. The NGO in London asked that I reimburse participants £10 each for travel expenses, which was more than reasonable.

community, and they were all Muslim. The focus groups lasted 1.5 hours¹⁰⁷. The NGO worker and I led the discussion by asking questions. The discussion was tape-recorded and the transcript was shared with the NGO. At the focus group in London, the participants' ages ranged from 18 to 70 and all participants had undergone FGM. The age range of the participants attending the focus group in Leicester was from 18 to 60. Four participants disclosed that they had been cut and seven participants did not disclose whether they had been cut. At the start of the focus group, I assured them of confidentiality and anonymity and outlined the terms of the consent form, while also ensuring the form was translated into Somali.

Although focus groups are an established method in market research, they have become a new method for sociological research (Reinharz, 1992). I intended to run at least one focus group because focus groups confer particular value in conducting and developing feminist research including: addressing feminist ethical concerns about the power of the researcher in the data collection process, generating high quality, interactive data and offering the possibility of studying the participants in the context of a social world (Reinharz, 1992). Feminist social scientists (Wilkinson, 1998) have expressed concerns about the power relationship between the interviewer and the participants, in which the interviewer has the power to control and regulate the conversation (Finch, 1993).

Wilkinson (1998; 1999) notes that the researcher's power and influence is reduced with focus groups because she has much less power over a group than over an individual. I was conscious of the need to reduce my perceived power and influence as a white middle class woman responsible for leading the discussion¹⁰⁸. The balance of power shifted to the participants in both focus groups when they took control of the topic of conversation and determined their own agenda. For instance, I did not intend to ask about FGCS until the end of the interview, but they frequently brought the topic into the discussion, eventually forcing me to consider their attitudes about FGCS surgery in depth.

Wilkinson (1998) suggests that focus groups have a valuable role in prioritising the voice of marginalised groups of women, for example lower socio-economic-class women of colour, because focus groups are a rare opportunity for them to "empower themselves by making

¹⁰⁷ Many participants stayed for around 15-20 minutes after the focus group to discuss the issues further.

¹⁰⁸ My outside status from the community was one of the key reasons the NGO worker led the discussion with me.

sense of their experience of vulnerability and subjugation” through dialogue with women who have had similar experiences (2000: 843). According to Madriz (2000), “active participation empowers group members who feel that their views and experiences are valued” (1995:12). It was important for me to ensure women’s voices are heard in this thesis. However, I have to reflect upon the fact that being *white* could impact upon how I analyse, interpret and understand black women’s experiences, which are inevitably different to mine, because they have lived in a context of racism and structural inequalities *because* of their race (Crenshaw, 1991). Furthermore, being *white* could impact upon how black women view me, perhaps as an outsider, which could change their responses to questions asked by a white researcher.

However, the racial divide appeared less apparent in the focus group context, as I was the only white woman in the room while 13 of the women were black of Somali origin, which may have affected the dynamics in a positive way. Participants interacted with others from their social world in a natural and relaxed manner. Women reported to me after the focus group that they enjoyed participating in the focus group, perhaps because of “the empowerment of self-expression in a supportive environment” and “the consciousness raising effects of group discussion” (Harrison & Barlow, 1995).

Moreover, focus groups can be seen as offering an important corrective to the study of the individual through one-to-one interviews devoid from their social context (Wilkinson, 1998: 116). They provide the opportunity to study how individuals collectively make sense of a deeply cultural, social and familial phenomenon in a social context (Wilkinson, 1998). The focus groups tapped into the construction of meaning around FGM through community dialogue amongst women of different age groups, as well as social and hierarchal standing in the community, offering the opportunity to observe the processes of interaction and the functions they serve. It was particularly interesting to observe the extent to which personal experiences of FGM were revealed, as well as the ways in which participants challenged and supported other participants and how the meaning of FGM among different generations was co-constructed in a group context (Bryman, 2012). Participants could have been reluctant to reveal personal information in front of other participants (Wilkinson, 1998). In addition, they might have feared disclosing personal views that support FGM when the NGO running the focus group aims to raise awareness about the harmful impact of FGM. However, not all NGO workers were against the practice and some defended it during the focus groups that they took part in.

Approximately nine of 11 participants relied on one interpreter in the London focus group and four of 11 participants required an interpreter at the Leicester focus group¹⁰⁹. Each interpreter worked for the NGO responsible for organising the focus group¹¹⁰. Very few researchers consider the effects of interpreters on research projects in their methodology¹¹¹. King (1981) argues for the need to extend critical reflexivity to the role of interpreters who are active in producing research accounts. The primary consideration when recruiting an interpreter according to Temple and Edwards (2002) is the interpreter-participant match, in terms of the same sex, culture, religion and age. Edwards (1998) goes on to explain that a broader emphasis is placed on interpreters being assimilated with the participants culture, so “they do not overlook or misinterpret the significance of certain responses or attempt to carry out the interview in an inappropriate manner” (1998: 200). Both interpreters matched the background of participants: women, Somali origin and Muslim.

Prior to the focus group, I asked the interpreters about their background in FGM and I informed them about my research. This helped to “reveal their own values and opinions,” which may have structured their interpretative work. The interpreters did not express a view about whether they were against or for FGM, instead they outlined the importance of the participants engaging in discussion about their attitudes towards FGM and their own experiences, which they described as an opportunity to engage in collective consciousness raising (Karsenas, 1987). Although I made the interpreters aware of their role and responsibilities¹¹², I was confident that participants would not fear that the interpreter would compromise their confidentiality or anonymity given the interpreters’ stakeholder role working for the NGO.

¹⁰⁹ The women who required an interpreter were first generation immigrants over the age of 50.

¹¹⁰ They had interpreted for participants at focus groups in the past and had significant experience of working with survivors of FGM.

¹¹¹ For a discussion of the importance of acknowledging the role of interpreters, see Freed (1988); Baker et al (1991); Edwards (1995, 1998); Temple (1997, 2002, 2000); King & Churchill (2000); Temple and Edwards (2002); Hennink (2008).

¹¹² I informed the interpreter to translate all discussions. However, Temple and Edwards argue there is no exact match for words, instead “the translator is faced with an array of possible word combinations that could be used to convey meaning”, thus “the translator is involved in discussing concepts rather than just words (2002: 2, 3). Also, see Temple and Edwards (2002) for a discussion about grappling with the semantic issues of translation.

The Interview Process for Women and Stakeholders

Initially I contacted participants by email or telephone introducing myself, explaining the purpose of the interviews, outlining the terms of the consent form and arranging a convenient time for the interview. I asked participants whether they would prefer to be interviewed by telephone or face-to-face. The majority preferred telephone interviews, partly due to convenience, as they were able to fit the interview in during their working day and often at short notice, or while at home caring for children. Appendix I set out the participants interviewed in person and by telephone.

I undertook several one-to-one interviews face-to-face in a public place, usually in a café that the interviewees chose or at their workplace¹¹³. All of the interviews were conducted in English. Both focus groups were face-to-face and conducted in English and Somali, thus I required an interpreter, which was provided by the NGOs that organised the focus groups. The interviews were recorded using a tape recorder. The interviews lasted between 20 minutes and 90 minutes. I did not pay the women¹¹⁴. At the start of the interview, I reiterated my assurances of confidentiality and anonymity. I drew the women's attention to the consent form and ensured they understood all of the instructions and that they agreed to take part in the research¹¹⁵. I explained to the participants that I was keen to hear what they had to say about their experiences of FGM and their views of the laws response to the practices.

The majority of interviews were conducted by telephone, which was cost-efficient and saved time, particularly when I needed to reach people scattered across England (Rubin & Rubin, 1996). In an era of technological development people have become more accustomed to virtual forms of communication by email, telephone and video messaging. Inevitably, evolving forms of communication impact on the changing nature of research methodologies. As telephone interviews have become more commonplace amongst social researchers over the last 50 years (Holbrook, Green, & Krosnick, 2003), there is emerging literature about the utility and quality of qualitative research conducted by telephone¹¹⁶.

¹¹³ I was aware of the potential for eavesdropping in public places and when this did happen I tried to change topic of conversation or indicate to the participant that our conversation was being listened to.

¹¹⁴ Nobody requested payment.

¹¹⁵ All participants agreed without hesitation.

¹¹⁶ See Rubin and Rubin (1996), DeVault and Gross (2007), Holbrook et al. (2003), Holt (2010), Roger W. Shuy (2003) and Sturges and Hanrahan (2004).

Miner (2012) opines that telephone interviews produce similar results to those found with face-to-face interviews¹¹⁷. In fact, Trier-Bieniek (2012) argues telephone interviews yield several advantages over face-to-face interviews, particularly in relation to feminist research. Notably, telephone interviews have “the potential for more honest discussions because of the anonymity involved, as well as an increasing security with virtual conversation” (Trier-Bieniek, 2012: 642). Like Trier-Bieniek (2012), I found that researching sensitive and personal issues by telephone interviews can benefit and even empower the participant because they are being interviewed in familiar and comfortable surroundings where they can control the direction of the interview. Moreover, as Miner (2012) notes, face-to-face interviews about highly sensitive and controversial issues involving gender, race and culture can be influenced by social desirability with participants giving answers that they believe the interviewer wants to hear, or will be considered positive. To an extent, telephone interviews helped reduce power differentials between the participant and the interviewer, because they were not face-to-face thus encouraging the participant to be more open about her experiences.

However, R W Shuy (2002) outlined the difficulties in building a rapport with participants prior to a telephone interview. Conscious of this, I spent time at the start of the interview engaging in small talk, asking them about their day, to help participants feel at ease. It is impossible to read the body language of the participants during telephone interviews. I could not see signs of agitation, stress or misunderstanding, making it difficult to recognise when my questions were particularly sensitive, when I should back off and when the participants were sufficiently relaxed and confident to try those questions again (Rubin & Rubin, 1996). Instead I had to interpret the tone and pitch of the participant’s voice and put into words communications that are normally nonverbal. This included asking the interviewee, “Are you okay talking about this issue” or if she found it too stressful I would say, “We can move on, we don’t have to discuss this” (Miner, 2012). Participants could not see my body language, so they could not see signs of interest or support. Instead I relied on verbal cues and changing the tone and pitch of my voice. While telephone interviews are less intrusive than face-to-face

¹¹⁷ Researchers have found that even in sensitive research – for instance, on prostate cancer – there were no major differences in the amount or type of information shared between face-to-face interviews and telephone interviews (Trier-Bieniek, 2012). Also, see Rubin and Rubin (1996) for a comparison of face-to-face interviewing and telephone interviewing in a qualitative study designed to learn visitors’ and correctional officers’ perceptions of visiting country jail inmates, which revealed no significant differences in the interviews.

interviews, I was conscious that they can still be affected by participant-interviewer interaction during the interview process (Miner, 2012).

Analysing the Data

In terms of data collection and analysis, I used grounded theory (Charmaz, 2011), which means theory is generated from data as opposed to testing prior hypotheses with data (Glaser & Strauss, 1967, 2009). It is of course inevitable that I approached the fieldwork with theoretical ideas informed from the literature. Indeed, the theoretical foundation for this research is one of feminism, international human rights, cultural relativism and critical race theory. It helped develop the semi-structured interview questions and focus group questions. The literature also assisted in identifying key themes and trends in the data. As stated above, I tape-recorded all of the interviews undertaken for this research study. During the transcription of interviews (in full) I started to identify key themes, which I listed in a separate Word document. I then coded the interviews using the qualitative data analysis software NVivo7.

Computer software helped to analyse the key ideas, themes and concepts from each interview, as well as checking the frequency of identified themes (Seale, 2000). It also invited me to think about codes that are developed in terms of interrelated ideas, urging me to consider possible connections between codes (Bryman, 2012). In addition, it helped demonstrate that the conclusions reached are based on rigorous analysis, such as the number of time themes occur, as well as demonstrating that I had searched for negative instances by examining the whole data rather than selecting only anecdotes supporting my interpretation (Seale, 2000).

There are several concerns associated with computer-assisted qualitative analysis. First, the interview process is fractured with individual stories told in an unstructured fashion, requiring clarification, interruption and the challenges of individual accounts. It has been suggested that the fragmentation process of coding text into chunks that are then put into groups of related fragments risks decontextualising the data and the narrative flow of interview transcripts may be lost (Bryman, 2012; Fielding and Lee, 1998; Weaver and Atkinson, 1994). To avoid the interviews being decontextualised and fragmented, I reflected on my awareness of the interview context and read the transcripts several times before even commencing computer data analysis (Bryman, 2012).

Second, computer-assisted qualitative data analysis is even more challenging for focus group data, according to Catterall and Maclaran (1997), because the code and retrieve function can

result in researchers missing the communication process that exists in focus groups. As a result, there are concerns that such analysis misses the most important aspect of focus groups, namely group interaction (Kitzinger, 1994). Following the suggestions of Catterall and Maclaran (1997) I attempted to mitigate these problems by ensuring I read the whole transcript several times and traced an individual's text in the context of other participants' text, which helped locate their discussions and analyse them in context.

Disseminating Research Findings

I intend to disseminate key research findings following the conclusion of the research study. During the thesis, I presented limited findings at academic and practitioners' conferences across the world. This assisted with gaining feedback on the thesis and the presentation of the research findings. Dissemination is critical to developing legal and policy change. However, dissemination is an ethical concern. All research findings are anonymised so no participant can be identified.

Conclusion

This chapter set out the empirical methodology for this thesis. Semi-structured in-depth interviews were chosen as a methodology, as it ensured multifaceted and rich data, which contributes to the limited volume of research on FGM in England. Undertaking interviews with women and stakeholders in England ensures the study is original and can be distinguished from other small-scale empirical research studies. The next three chapters discuss the data from the interviews with women and stakeholders in the context of the theoretical, policy, legal and political reflection as outlined in chapters one, two and three. The methodological foundation as set out in this chapter, particularly the importance of giving a voice to women, serves as a method of analysis as outlined in the three empirical chapters.

Chapter Four:

Understanding Women and Girls' Experiences of the Motivations for Female Genital Mutilation

“If you get married... the next morning parents from his side and your parents come to investigate that you were a virgin, which means you will be lying in a pool of blood and they will be celebrating the blood around your bed. As my cousin said, she was groaning like a wounded animal in a pool of blood and her mum and his mum [mother-in-law] were dancing around their bed instead of helping her first.”

[P12, FGM-PCM and teacher, *Somalia*]

Introduction to the Empirical Chapters

Chapters three, four and five outline the findings from the qualitative data from semi-structured interviews with women from FGM-performing communities and interviews with stakeholders. The chapters are structured on the basis of key themes arising from the analysis of the interview data. It is not possible to outline all of the themes that emerged from the data due to a stringent word count for the thesis. The themes that are highlighted in the empirical chapters assist in answering the overarching research question of why FGM persists despite its criminalisation. Chapter four presents women's experiences of FGM and their beliefs towards the motivations for FGM. Furthermore, it analyses stakeholders' understanding of the motivations for the persistence of FGM. Chapter five and six link the legal and policy frameworks for FGM with women's and stakeholders' attitudes and beliefs towards legal and policy measures.

Throughout the empirical chapters, I draw upon the literature, political narratives and legal and policy measures to highlight comparable material with the data findings. This thesis presents micro and macro scales of women's and stakeholders' understandings of FGM. First, I explore women's experience of the practice first-hand and second I examine stakeholders' attitudes towards the practice and the design and implementation of legislation and policy.

The majority of women referred to the practice as female circumcision rather than FGM during the interviews because the term circumcision is normal within FGM-performing

communities, thus they rejected defining the practice as FGM or mutilation. I referred to the practice in the term interviewees used. The exception to the rule was women who were part of the anti-FGM lobby. In those cases, women referred to the practice as FGM.

While children were not interviewed during the research, women described their own experiences of FGM when they were children and they considered other children's experiences of the practice. Childhood and FGM are intertwined throughout women's narratives of the practice, which is perhaps not surprising given FGM is largely performed on children.

The data derived from interviews is set out as quotes. The quotes from interviews with women provide information about the interviewee and the participant number in the form of tags accompanying the quote. For example, "[P1 FGM-PCM, *Somalia*]." The number "P1" refers to the participant number, further details of the participant can then be identified in Appendix I. "FGM-PCM" is an abbreviation for "FGM-performing community member." The country written in *italics* refers to the country of origin of the participant. In the event the participant also undertook employment that was relevant to the study, i.e. teachers, police officers or social workers and their employment comprised part of the interview data, I use the following tag, for example: [P2, FGM-PCM and teacher, *Gambia*]. I simply add the name of the profession to the interviewee tag, i.e. "teacher."

For stakeholder interview tags, I use the following format "[P3, Member of Parliament, M]." The tag states the participant number so further information about the interviewee can be found in Appendix I. The defining role of the stakeholder is denoted, i.e. "Member of Parliament." The final information provided is "M" which represents the gender of the participant. If the participant were female it would state "F."

For the focus group tags, I use the following format "[FG1]." "FG" is an abbreviation for focus group and the number indicates whether the tag refers to focus group one, which took place in Leicester, or focus group two, which took place in London. All participants were of Somali origin so I do not denote the country of origin of participants.

Introduction to Chapter Four

This chapter highlights the data from interviews with women and stakeholders. I explore the realities and perceptions of the practice of FGM in more detail. This chapter examines the

first research question of the thesis: What are the motivations for continuing the practice of FGM? Understanding the motivations for FGM may explain why the practice persists despite its criminalisation. In the first part of this chapter, women's experiences of FGM are examined, which provides an overview of the key motivations for its persistence. The second and final part of the chapter sets out the data from stakeholders' interviews of the main motivations for the practice, which provides a comparison and sharp contrast with women from FGM-performing communities' attitudes and beliefs. The views of stakeholders give insights into their perceptions of the practice, which impact upon how they seek to implement the law. This chapter invokes intersectional issues of gender, race, class, culture, nationality and religion.

Re-thinking the Core Reasons Women Give for Performing Female Genital Mutilation

Women from FGM-performing communities discussed the key motivations for performing FGM. Identifying the factors that underlie the continuation of FGM relates to later chapters, which explore the barriers to anti-FGM laws functioning effectively in eliminating FGM. Women who have undergone FGM discussed their own personal experiences of the practice in detail. I did not ask interviewees to describe their own experience of FGM but instead asked broad questions with prompts, including "What are the key motivations for performing FGM in your experience?" When women discussed their own stories, I provided space for them to explore the issue as I took the role of a listener. During one-to-one interviews women often went into detail about their own stories of FGM. I followed up with open questions, which invited them to provide further information. During focus groups, women did not relay their own stories. Instead they talked about the practice in a depersonalised way perhaps because the context of the discussion did not appear private but public due to there being a group of women in the room who had different opinions towards FGM.

As addressed in the introduction and the literature review chapters, there is no single reason for the continuation of FGM. The reasons for performing FGM usually depend upon the meanings ascribed to FGM by different tribes and communities. The data shows the diverse experiences of FGM and the similarity of the motivations for the practice. Those that organised FGM were largely family members either abroad or in England. The discussion of FGM in this thesis focuses on FGM in the context of familial relationships involving the whole family, which is reflected in the quotations of interviewees. When exploring the motivations for FGM, I reflect upon the literature cited in earlier chapters to see whether

scholars' opinions relate to the empirical evidence. This chapter explores four recurring motivations for FGM that emerge from the data: control of girls and women's sexuality, preservation of a cultural practice, consequences of living a life uncut and religious requirements to undergo FGM.

Controlling Girls and Women's Sexuality

The most prevalent motivation for FGM discussed by all women interviewed was to control girls and women's sexuality. Women identified that the purpose of FGM was to ensure that they are marriageable, to maintain a girl's virginity until marriage and ensure women's fidelity to their husband after marriage. Control of a girl and woman's sexuality is the most documented motivation for FGM in the literature. Dorkenoo (1994) and Toubia (1994, 1995a) have both written extensively on the purpose of FGM as a means of controlling who, when and how a woman has sex and reproduces. FGM is regarded as a physical chastity belt (Toubia, 1995: 299). A survivor and teacher from Somalia explained the main motivations for FGM:

From my culture, the main motivations [of FGM] are purely to keep the virginity, to protect the virginity to keep the family name intact. Because if you get married it's like the next morning parents from his side and your parents come to investigate that you were a virgin, which means you will be lying in a pool of blood and they will be celebrating the blood around your bed. As my cousin said, she was groaning like a wounded animal in a pool of blood and her mum and his mum [husband's mother] were dancing around their bed instead of helping her first. So you can see how deeply [engrained] the culture is. [P12, FGM-PCM and teacher, *Somalia*]

This participant describes her family celebrating the physical spectacle of her cousin having lost her virginity to her husband. The wife's virgin status reinforces her family's honour within the community. The interviewee's story shows that FGM signifies honour within familial and community relations because it is imbued with notions of virginity and chastity. The interviewee describes the virgin status of her cousin as represented in the physical pain and blood that followed the consummation of marriage. Women's bodies symbolise pain and conflict as they undergo FGM and as they consummate their marriage.

According to radical feminists Hosken (1979), Daly (1990) and Walker and Parmar (1993), a key motivation for FGM is to oppress girls and women's agency over their sexuality. The

woman participant above describes a practice that could be interpreted as oppressive to women. As discussed later in the chapter, the difficulty is that there is a divide in attitudes towards FGM, as some women do not believe the practice is oppressive. This reflects the divergence of views of scholars in the literature review. Applying an intersectional analysis, FGM is not simply about the control of women's bodies, it relates to their identity, religion, culture and nationality. Other motivations for FGM are explored later in the chapter.

Although it was difficult to gain access to men, I managed to interview two men from FGM-performing communities. They explained that FGM is performed to remove sexual feelings from a woman to ensure fidelity to her husband:

The reason behind it [FGM] is to stop promiscuity. The reason is to stop them having too much feeling for sex or something, you know, that's the main reason behind it, so they stay with their husband. The reason is for the woman not to be promiscuous, to be calm and be with one's husband, people who do that to their children, they want their children not to have too many feelings towards men so they will not be wayward. So if there is no feeling they will wait for marriage. [P14, FGM-PCM, *Ghana*].

The startling feature of the quotation is that the interviewee believed FGM should be performed to remove women's sexual pleasure and desire. The implication being that FGM is a source of power and control over a woman to ensure she marries and is faithful. Notably, the men did not reject the practice. Women's understandings of FGM are complicated. They reflect the two schools of thought about whether FGM is oppressive or empowering for women. African-American scholar Ahmadu (2000) argues that FGM is controlled by women, it is an empowering practice and it increases their social status in the community. In contrast, Hosken (1979) would argue the attitudes of the male participants corroborates the writings of radical feminists that "the sexual castration of women is the purpose of the operations" (73). The divergent attitudes towards FGM in the interviews are a theme throughout the literature review and it continues through the empirical chapters. Rather than stating my own opinion, it is important to allow the participants to speak for themselves. In the conclusion of the thesis (the final chapter) I provide a critical analysis of the empirical data from my own perspective.

Similar to the men interviewed, women vigorously argued in support of FGM on the basis that women's sexual desire is curtailed while men's sexual pleasure is maintained. A participant in the focus group stated that she preferred type I FGM as opposed to type III

because type I enhanced men's sexual pleasure while women's sexual gratification was limited:

The sunna [type I FGM] is totally different. The pleasure for men is still fine [first observation] because the entrance is not affected so for him it's totally fine. However, with the women it depends on, it varies from one woman to the next. This feeling is not only clitoris based because it's still there. So she will still have some feeling. Some of them will have normal feeling, some women have partial feeling, some of them, it depends. [FG1]

When the focus group participants discussed sexual pleasure, their first thought was the sexual pleasure of men. Similarly, a survivor who had undergone type IV FGM described her own experience of labia elongation, which included graphic descriptions of the physical pain endured. When reflecting on the motivations for the practice she stated that it is performed for the benefit of men's sexual pleasure.

When I was 7 years in Zimbabwe... they would take us to a secluded place like near a river and then they would start pulling our clitoris and labia. It was elderly women in the neighbourhood who were specially trained to do that. They used a wild fruit which they first roasted in a high heat pan and then it became roasted and then they started grinding it to make it powder. Then after it is powder they mix it with cooking oil and then that's the herb that they used. They used their fingers to do that for girls whose girls clitoris was hard they used pegs... they suffer from it because it resulted in them have cists... then there are others who are having problems giving birth and sometimes they have to go surgery... because it doesn't have aesthetics for some young girls once you go there the next day you come back with a lot of pain, then you are start actually feeling the pain, a lot of pain. Some women get their genitalia swollen, some women react to the herbs. So it gets abnormal, like they have a lot of infections the day after that cannot be easily infected, so you end up treating infection after infection... The reasons were that we were supposed to prepare so that when men have sex with us they have their pleasure and then it was done because they said many young women who got married without doing that were returned back to their homes and rejected at the marriage age because that was not the norm... [P2, FGM-PCM and NGO worker, *Zimbabwe*]

The narrative shows that marriage and men's sexual pleasure achieved through FGM are prioritised over a girl's right to bodily autonomy to *choose* to undergo such practices. A

woman from an FGM-performing community and social worker reflected on the motivations for women undergoing type IV FGM (labia elongation), to increase the sexual pleasure of men.

I know friends from Southern Africa who have gone through that [labia elongation] but you see the irony is they don't talk about it in a negative way. They are very proud of what they went through. They see it as a badge of honour. Some of them went through when they were a young age, others in their early teens. They talk about the whole process and they laugh about it. I am not sure if they were even aware that was abuse... They all talk about it in a very positive way and they haven't experienced any pain with it. I am from West Africa and they are from South Africa and sometimes there is this banter because a lot of Western African men seem to be dating South African women and they say it's because of the labia elongation and that's why they like them. And this is how these conversations start out. So to them they have something the Western African women don't have which is why the Western African men are going to them... I think it's more to do with the men. It's a discussion about how men find them attractive. Men enjoy having sex with them because of the way their clitoris looks or things like that. [P75, social worker]

The participant suggests there is a hierarchy of FGM, which is dependent upon the type of FGM performed. In this context, women who have undergone type IV FGM experience elevated social status due to the increased sexual arousal of men emanating from women's elongated labia. Women participants accept that one of the motivations for FGM is increased sexual pleasure of men. However, participants appear to accept this motivation without challenge rather than thinking critically about whether this is an acceptable reason for the persistence of FGM.

Another purpose for performing FGM is the need to clean and purify a woman's body, physically and psychologically. According to the findings from the interviews with lower-class women in Egypt, Malmström (2016) reported that women believe they are neither clean nor pure if they have not been cut. Academics Kouba and Muasher (1985) in their dated research argue that some tribes and communities believe FGM prevents disease and is associated with cleanliness in the sense of hygiene. Cleanliness and purity also denote the virgin status of women. Two women of Somali origin linked FGM to hygiene and virginity:

I honestly have heard that guys, you know like she said, some guys like to know if a girl has been circumcised because then it shows that she is pure, she's untouched. [FG1]

It [FGM] enhances the female aspect of the body or female psyche, or how she should be clean, pure woman that would be perfect when her husband would marry her. [P7, FGM-PCM, *Somalia*]

Furthermore, participants in the focus groups gave a robust defence of type I FGM on the basis that it ensures cleanliness of women:

- I just want to add that there is a reason why it's a sunna [type I FGM] and there's a big reason behind it. There's a bigger picture to it. The reason of why sunna is hygienic.
- Basically the type I, the one that is encouraged, the clitoris, it needs to be not cut but blood needs to come out of it, they believe that blood inside that clitoris is not something that is pure and after that blood is drained out then it becomes nice and clean and pure. But the cutting behind it I think is taken out of proportion that it's being cut and all that. But the cutting is not part of the religion. They believe it will become elongated so at least it needs to be cut and then it will look nice. [FG1]

Type I is perceived as more hygienic than other types of FGM. The draining of the blood from the clitoris is believed to ensure purity and cleanliness. For this reason, type I FGM could be maintained because of the cultural beliefs that genitalia are unclean until cut.

Preserving the cleanliness and purity of a woman's body through FGM is also perceived as a manifestation of beauty. Beauty is a prime driver for performing FGM. Somali women in the focus groups, mainly elderly women aged over 60, described FGM as a form of beautification. Participants in the second focus group in London included a grandmother and her granddaughter. The grandmother was responsible for having her granddaughter cut in Somalia.

- Grandmother: If I am being honest she said, I have three girls, when I was in Somalia, one died in infant age, the other two I did circumcision, I did pharaoni,¹¹⁸ because that was the fashion at that time and I believe still, I

¹¹⁸ Pharaoni or pharaonic circumcision refers to type III FGM.

believe it still today that they were the best girls and I have never seen any problem with them, on their body also and their genital was beautiful for me like it has been. She believes that the age that the elder woman, of the elder woman my age, we are the same age who has not been circumcised, I believe that I have a beautiful more prettier vagina than them, those who have not been circumcised. I believe and I can demonstrate also that I am clean. I can show you, I can show you that I am clean. And the circumcision that I had was pretty and I am more, more pretty, I have more prettier vagina than those who have not had it. I was happy because I believe that when the woman who have not been stitched and has not been cut it was very, very ugly her vagina, I was happy then because I was having this pretty vagina after my circumcision.

- Granddaughter: In Somalia culture if the woman has a larger clitoris or things are too like messy they want it to be tidy and neat. I think, because me and my grandmother discussed this and it's for the women's satisfaction.

[FG2]

The grandmother and the granddaughter use similar language and narratives to Western women who advocate for cosmetic procedures and thus promote the beauty industry. The participants argue that FGM is liberating because it enhances the appearance of the genitalia and is carried out for “women's satisfaction.” Type III FGM is described as “fashion” through enhancing the aesthetic appearance of a woman's vulva. Although cultural norms dictate beautification practices, the participants frame FGM as stemming from a woman's individual choice outside cultural influences. A comparison can be drawn between participants adopting the Western rhetoric of choice to undergo FGM and Western Muslim women who also adopted Western language of freedom and choice to assert their right to wear the Islamic veil in studies conducted by Killian (2003) and Shirazi and Mishra (2010)¹¹⁹.

Narratives of beautification and choice are used to detract attention from the underlying dominant purpose of FGM, to control a woman's sexuality. Cultural pressures to undergo FGM are implicit in the language used by participants. The grandmother distinguishes between vulvas that are cut and are beautiful and those that are uncut and are in her words, “very, very ugly.” According to the participants, women are expected to fall into dualisms of beautiful vulva/ugly vulva and clean/dirty. The fear of falling into the ugly/dirty category ensures the persistence of FGM even when it is criminalised. Women participants were

¹¹⁹ See the literature review in chapter two for a full discussion.

unable to think outside of this dualism to consider an autonomous existence. However, while I apply a feminist analysis to the data, women themselves do not regard FGM as a means of controlling women and even if they did, they would still defend the practice because it is integral to their identity and sense of belonging. An intersectional analysis of the motivations for FGM between notions of gender, race, class, nationality, culture and religion is imperative to understand why women continue to perform the practice. Later in the chapter, I explore cultural and religious motivations for FGM.

Women have a key role in maintaining control of women's sexuality through performing FGM. A teacher and survivor of FGM describes the role of grandmothers in particular in maintaining FGM:

Interviewer: Who decides whether a girl should be cut?

Participant: Woman. Woman driven. Normally mothers who make the decision but if you are living in an extended family like Somali people do it's usually the grandparents and there is no way you are going to escape FGM if you have your grandparents in the house. Grandparents are held up high, whatever they say goes, they are extremely powerful, it's a status thing, it's a respectful thing. So whatever they say goes in the family. They actually even choose who married who. In my family, cousins marry cousins. They pair them up. [P12, FGM-PCM and teacher, *Somalia*]

The participant notes that grandmothers are given an elevated status in the community. Some grandmothers use their position to enforce such practices upon girls and women. Dorkenoo (1994) contends that "after the menopause patriarchal society has no need to control women's reproduction or sexuality as they can no longer bear children," as a result older women gain status and power within the family by performing the practice on the younger generations (49-50). African-American scholar Ahmadu (2000) regards FGM as an empowering practice for grandmothers because their status is elevated and they maintain the cultural practice upon the younger generation. An FGM survivor and teacher explains her view of the reasons for women's involvement in FGM:

All FGM is driven by women because of protecting virginity. They are afraid to be segregated from the community. They are afraid to be talked about, because they would be talked about because they would say oh her girls are dirty, her girls go with boys easily, they are kind of sluts, Somalis won't want to marry a girl if they know she has not been cut. The rest will stay away from you. Some of the women don't

want to cut their girls but they don't know where to go for help. If they want to talk to some professionals, but there is nothing here like that. If they are under pressure from the family side they will buckle under because there is no one to talk to about what's going on. [[P12, FGM-PCM and teacher, *Somalia*]

Some women believe the fear of the social consequences such as social isolation from the community ensures women continue to perform FGM. Indeed, women might fear that ending FGM could jeopardise the promise of elevated social status. In this context, women do not view FGM as an empowering practice. It is a means of maintaining their limited social status in a patriarchal society. A survivor and midwife describes the role of women and men in the family in maintaining FGM:

Interviewer: Who decides if a girl should be cut?

Participant: I think it's mostly the grandparents. For me it was my stepmother. It is mainly the women of the family. Still we have this shadow of the men. Don't think the men are not involved with that. Because men are not saying no so they implicitly say yes because when a girl is cut they go out or they like just leave the place and so that's the way for them to agree because like I have my grandfather and he sat down everyone in the family and said you have seen I have got three girls they have been born in a certain way and I don't want anything done to them. So I think men are implicitly guilty of the FGM even when it's carried out by females. [P9, FGM-PCM and midwife, *Mali*]

While women have an active role in organising and performing FGM, men are also involved in perpetuating FGM because they do not actively object to FGM. In the case of the participant, it was only after her grandfather objected that FGM ceased. Men have a central role in defining cultural traditions. Having discussed the control of women's sexuality as one motivation for FGM, I will now move onto exploring whether fear of the consequences that ensue when women and girls have not been cut reinforces the practice.

Fear of Transgressing Social Norms and Breaking Taboos

A prime motivation for continuing FGM is fear of the social and cultural consequences that might ensue if women do not undergo FGM. According to Gunning (1999), the consequences can include isolation from family, friends and the community to being outcast and viewed as dangerous or dirty for not undergoing FGM (659). A survivor of FGM from the Gambia

explains that failing to undergo FGM has a significant impact on women's roles in their families and communities:

Before they cut you, if you cook, people will not eat it because they will say this is the food of someone who is not cut. So the food is not clean. People should not eat it. That can even lead you to tell them to hurry for the ceremony to take place to be cut, so you have space in the community. [P3, FGM-PCM, *Gambia*]

Uncut women are punished for not conforming to FGM by preventing them from performing a key aspect of their gender role for example, cooking. The cultural myth that uncut women are unhygienic and even dirty and could contaminate the food is a form of social control, gender policing and in its darker manifestation, a hidden form of social violence. The social costs of being uncut reinforce cultural pressures of continuing FGM. Given the dire consequences of being uncut, women in both focus groups explained that girls ask to be cut:

- Sometimes she is looking forward to this thing being done because otherwise her classmates will tease her if she hasn't got FGM and she's dirty. They find her dirty if she is uncut. If the girl is uncut they will tease her otherwise.
- So if your friends are circumcised before you and you haven't been done yet they will tease you. So basically it's for your own benefit to get cut in some cases.
- I should be ashamed if I am not cut. That social stigma. Society feeds that idea that she should get cut otherwise no one will marry you. Then if she does get cut, psychologically she is sound. The day that she does not get she might feel like, why am I not normal. I want to be just like the other girls. [FG1]
- You know back home this is something every girl has to go through and if the girl will not go through to her circumcision it was really bad for her. Stigmatizing, teasing by all the other family, also stigmatised by other families and neighbours and so she said every girl was expecting this, especially when there was circumcision of pharaoni and the sunna one.
- Because the worst thing is if we are not circumcised how can we be in the society and live with integrity? [FG2]

The stories of participants reaffirms scholars' writings that young girls approaching adolescence and under the pressure of peers, ask their parents to have FGM performed on them (Lightfoot-Klein, 1989; Toubia, 1995b; Wilson, 2002). In a village in Western Kenya

studied by Walley (1997), where FGM is performed on girls aged 14 to 16, girls enthusiastically look forward to their “initiation” ceremony, inviting family and friends to attend (Wilson, 2002: 497). An FGM-performing community member describes girls asking for FGM so that they can perform their ascribed role in their communities as wives and mothers, which gives them a sense of belonging and identity:

If you want to get married or if you want to have a life, or take part in society then you get it [FGM] done. If you don't want to take part in society then you don't get it done. [P5, FGM-PCM, *Somalia*]

The participant highlights that a woman who is uncut is unable to marry and has no role in society. She is isolated from her family because her very existence represents the transgression of social norms, which threatens the fabric of their community. A woman from an FGM-performing community who was the first generation of her family not to be cut describes the social and cultural consequences of not undergoing FGM:

Because we are not cut, they speak to us like we are so western, we are modern, we are cheap, they think because we haven't had that kind of training or that background, they think oh you are loose women, definitely, they think that, loose women. You've got no sexual respect. When actually you've got people who have been cut that are really promiscuous. Being cut didn't make a difference to their sexual behaviour. It depends on how they've been cut. For some, sex is painful. [P6, FGM-PCM, *Nigeria*]

The participant's excerpt shows that uncut women are dismissed as modern, cheap and loose. The abuse that uncut women receive could reinforce the cultural and traditional status quo of performing FGM. The implication is that an uncut woman is fair game for abuse because she has transgressed cultural norms. The abuse uncut women experience silences other women who might have argued against FGM. The remarkable aspect of the passage is that the participant does not challenge or criticise the gendered norms of virginity and chastity associated with FGM. Instead, she reinforces these norms by arguing that uncut women are as “pure” as cut women. This section touches upon cultural norms in reinforcing the practice, I now move onto exploring whether maintaining cultural practices is a core motivation.

Clash of Cultures: Maintaining Cultural Traditions in Migrant Communities

Participants identified the preservation of culture as a dominant motivation for continuing FGM. It is important to explore the complex role of culture in understanding women's experiences of FGM, which are mediated through structural forms of oppression, such as racism and colonialism (Coleman, 1998; Sokoloff & Dupont, 2005). A participant in the first focus group described FGM as a deeply embedded cultural norm that remains unchallenged:

Interviewer: Who decides whether a girl is cut?

Interviewee: Primarily the mum. Whether a child goes to school or not, this is not something that is discussed. Something like that it's natural. It's like I'm just going to get circumcised. [FG1]

A Somali woman from an FGM-performing community describes the link between the persistence of FGM and feelings of loss and distance from 'home,' their country of origin:

If you want to criminalise female circumcision, you could criminalise it but if a community want to keep continuing female circumcision and the reasoning is something along the lines of, we live in a foreign country and we want to keep our tradition alive and for us living in a foreign country is traumatic and we want to keep it for our own piece of mind, whatever reasons they give you, that could be deemed as a mental, a form of mental kind of coping mechanism. [P7, FGM-PCM, *Somalia*]

Intersectional issues of culture, belonging and nationality are identified within this powerful quotation. The woman describes her experience of being a migrant in a country in which she feels distant without a sense of belonging. The experience of migration can result in a cultural clash, which leads to migrants preserving their nationality and identity. In this context, women hold onto the cultural practice of FGM as a means of maintaining their culture and identity in a country in which they feel distant. While intersectionality is imperative to understanding the persistence of FGM, stakeholders do not analyse the practice with an intersectional lens, instead they apply a reductive lens of child abuse or violence against women. Many stakeholders struggle with the role that culture might play in perpetuating FGM and they struggle with how to talk about the relationship between the two (Sokoloff & Dupont, 2005). This may be one reason why stakeholders have not been able to address FGM even when the practice is a criminal offence. This is explored in the second part of the chapter.

There is a fear amongst immigrants that when they migrate they are no longer culturally bound. Similar to African-American scholar Ahmadu (2000) and anthropologist Shweder

(2000), participants identify FGM as a culturally significant practice, which is an integral ritual to maintain the cultural identity of communities. During the focus group in London one woman explained the importance of maintaining culture by performing FGM:

Interviewer: What reasons do people give for cutting girls in the UK?

Participant: Because they still believe to continue and carry out the culture. And because if they leave this they may think they are leaving something. So they may feel it is still valued to be carried out, it's their duty and they are the person to pass it on to their children. So it's like carrying out some values, that's what they believe [FG2]

One of the ways to maintain links with cultural traditions in their country of origin is through ensuring the next generation undergo the same cultural practices as their kinship in their country of origin. This creates a sense of shared identity and belonging. However, while FGM might appear a static practise, a survivor of FGM from Sierra Leone believes culture is constantly changing:

We started campaigning about it but some of them are still in the denial stage saying that it's a culture, a tradition. I will argue with them, I will say culture, tradition, who made the culture and tradition, tradition didn't come from God, it's men that made the tradition, the culture, we can amend it. We can keep culture that is good for humans. Those traditions and cultures that are not good for human beings. I gave them an example I said before we used to have facial marks I say do you see people with facial marks now. We need to change the cultural tradition. [P10, FGM-PCM and social worker, *Sierra Leone*]

Attempts to challenge cultural practices are met with suspicion and distrust. Confusion about where the practice stems from shows the deep-rooted normalisation of FGM. Indeed, when people understood that God does not sanction the practice, attitudes towards FGM changed. The participant drew on facial markings to show a change in cultural practice, as this is no longer performed. Another way to change cultural practices is by integrating FGM-performing communities into Western culture according to the first focus group participants:

- People who have been in these countries or in Europe it's not something they agree with, the majority. However, if people sometimes come fresh from Somalia in the rural villages they still practise and they still think it's a good idea. So generally I think it depends on educational background and where they are from.

- I think it's the fact that people have migrated to Western countries where this thing isn't practised, it's something that is completely alien to the country that you're coming to so even though there weren't any laws against it until recently here, people just didn't practise it because you are trying to integrate into the society that you've come to live in.
- So our parents and grandparents and great-grandparents came to live in Europe from Somalia they tried their best to try and integrate into the society that they were living in whether that's Holland, Denmark, Sweden, or here or whatever, so you are trying to integrate. And doing FGM isn't really integrating, it's going against the status quo of the country. So I think religious put aside I think the fact that people migrated to Western countries is another reason why people have stopped. [FG1]

The participants drew a stark distinction between immigrants who recently arrived in England and are not integrated into Western society and those who have been in England for a lengthy period and have assimilated. The interviewees believed assimilation is key to changing cultural attitudes. However, black women's experiences of racism and structural inequalities may result in women resisting assimilation and reinforcing their cultural practices to maintain a sense of identity. This was not fully explored in the interviews due to time constraints and the limited parameters of the study. A teacher and survivor from Somalia highlights her own experience of assimilation and changing cultural attitudes in the context of a discussion with her mother:

For some reason I said if I ever have a baby girl she will be never ever touched. Her [my mother's] face dropped, like how dare you, her face dropped... I said I am not going to cut my girl and you have a face. So which one, she said people are going to talk about you, I said I don't care we are in Europe, who talks. [My mother said] nobody is going to marry your girl, it's their job to find their own husband, not me, they will have freedom that I didn't have, I will make sure of that, they will marry whoever they want. She said "oh my god you are becoming western." I said it's not western its freedom which you took away from me. Freedom why they cut me this way, to protect my virginity. They cut to control your sexuality [...] I haven't heard anyone say I don't want cutting done. I haven't seen that. Parents still believe in FGM, my own sister does [P12, FGM-PCM and teacher, *Somalia*]

The passage shows that when there is increased assimilation of the younger generation, it appears likely FGM will be abandoned. The survivor described Europe as a context in which there is no cultural pressure to perform FGM. However, the pressure exerted by her mother,

who is 80 years old and has lived in America for 30 years shows older generations' resistance to abandoning the practice and their ability to maintain control in the community. Culture is clearly a core motivation for performing FGM, however in the next section I address whether religious beliefs towards FGM have a role in continuing the practice.

A Strong Religious Belief in Female Genital Mutilation

Some women interviewed regarded FGM as an Islamic practice. It is clear from the interviews that religion is important to women's sense of identity, therefore linking religion with FGM results in the continuation of the practice. Whether Islam requires FGM is a highly contested and debated question (Boyle et al., 2001: 527). Confusion surrounds the religious status of type I FGM in particular. Unlike the other types of FGM, type I is specifically referred to by interviewees as Sunna. Sunna means a practice that is 'advised' in Islam (Boyle et al., 2001: 527). An Imam explained the Islamic origin of type I or Sunna:

The sunna means acts saying deeds of the prophet of doing something that it is advised by the prophet... Here's an example, he found the woman who was carrying out circumcisions in Medina. The verification of this is uncertain. My understanding was he said, let's leave something hanging out. He didn't speak in scientific terms, did he? He said it's allowed providing it's not cut all the way. He said leave something hanging out. [P45, Imam]

The Imam's understanding of the Islamic origin of type I FGM reflects scholar's understandings that:

"There is a *hadith* that addresses the practice of female genital cutting directly. It described Mohammed suggesting to a midwife that excision is "allowed" but should not be "overdone" because a more limited cutting "brings more radiance to the face... and is... better for the husband"... the *hadith* is contested, however, because the relevant authority is obscure and its genealogy questionable" (Boyle et al., 2001: 527; Coleman, 1998).

While the Hadith is contested by some religious scholars and anti-FGM advocates, it is clear from the interviews conducted that women interviewed were aware of the religious origin of FGM, as they recited the same Hadith. Women that rejected FGM also rejected the Hadith and instead defined the practice as emanating from culture and religion.

It's clear that it's something to do with tradition and nothing to do with religion...
[P1, FGM-PCM, *Somalia*]

Women that supported the practice of FGM explained that religious observance is one of the rationales for performing FGM. Findings from the focus group show that religion is a motivation for performing FGM. My findings therefore differ from the assertions of academics. Boyle et al. (2001) argue without evidence that most Muslims do not perceive FGM as a religious requirement. The women in the focus group believed FGM is an Islamic practice:

- The sunna one is criminal. So although we believe religiously sometimes it's advised, it is still illegal? I think that's wrong because people's religious values should mean more to the legal system than prettifying your [vagina]. I mean I know your self-image is a lot, your religious views are also a lot. In a way it is self-image anyway, because if you believe and that's your religion then doing it.
- The argument isn't whether this is a must or it isn't. The argument is that it's part of your religion if you want to do so, if you choose. The fact that the law is preventing you from practicing your religion if you want to do it. [FG1]

Participants did not describe women that undergo FGM for religious purposes as victims. Parallels can be drawn with academic's critique of a public discourse of victimhood projected upon women that uphold cultural or religious practices (Bilge, 2010a; Mahmood, 2011; Meyers, 2000). Applying an intersectional analysis, women's religious beliefs are integral to their identity, which in turn maintains FGM. When women became aware that all types of FGM are a criminal offence, they forcefully opposed criminalisation because they believed the law infringes women's right to practice their religion. Women resisted anti-FGM norms and representations of women as victims by emphasising their agency to consent to FGM (Bilge, 2010a; Yegenoglu, 1998). Rather than the law operating as an effective tool of advocacy to change attitudes and beliefs towards FGM, the law could encourage communities to reinforce FGM. This is explored further in empirical chapters five and six.

Stakeholders' Understandings of the Motivations for Female Genital Mutilation

Having explored women's understandings of the motivations for performing FGM, the latter part of this chapter examines stakeholders' understandings of the motivations for continuing FGM. Indeed, stakeholders' understandings of the practice could impact upon how they seek to implement the law¹²⁰. Stakeholders' responses to FGM are rarely, if ever, explored in the literature. This provides an opportunity to compare and contrast stakeholders' attitudes and beliefs about FGM with women's attitudes. An intersectional analysis of the data is provided to ascertain whether stakeholders view FGM through a lens of gender, race, culture, class, nationality and religion.

According to the stakeholders interviewed, the main reason for the persistence of FGM is to control a girl's and woman's sexuality. A civil servant from the Department of International Development succinctly highlighted her understanding of the purpose of FGM:

This practice is like 4,000 years old. It is deep-rooted. Where it's practised, it's done because that is what we do. It's not a big decision to get a girl cut traditionally, it's just a part of life and it's held in place because of different reasons. But on the whole it comes down to being essential for a girl to get married and it's disastrous if she doesn't because there are no other options and every family expects a girl to need to be cut to get married and if you have a son then he's going to marry a cut girl. And you can't decide as an individual not to do that even if you don't want to do it because, you know, you are condemning your daughter to not get married, to be ostracised. In some communities uncut women can't serve food to guests so on and so forth, the social sanctions are really, really strong... possibly practising it for reasons relating to cultural identity and protecting their daughters from what is perceived to be a very sexualised culture rather than marriageability, traditional reasons in high prevalence countries. [P18, Civil Servant, Department for International Development, F]

The participant listed the key reasons for the practice such as control of women's sexuality and cultural norms, which shows a general understanding of the practice. However, there was no critical reflection of why these motivations are persistent or substantive exploration of at least one motivation identified. This might reflect the participant's limited knowledge. It appeared that participants' attitudes reflected media and political discourse.

¹²⁰ The link between stakeholders' understandings and how they seek to implement the law is explored in the later empirical chapters five and six.

All of the stakeholders focused on the control of women's sexuality to explain to the motivations for FGM, including a local authority employee:

Interviewer: What do you think are the motivations for FGM?

Participant: Power and control over women. I think it's one way to control a woman's sexuality, to control her life choices. It's a process that will then kind of show that young girl that you don't have a choice and we all know that a lot of people think it's a religious practice because people say it is a religious practice. And they are limiting a girl's choices, you don't have control over your body, we have control over your body, religion has control over your body. You shouldn't have sexual relationships, healthy sexual relationships that you are there just for one reason only and that's to be controlled whether that's in your life before you're married and then after you're married as well. To uphold chastity that you're clean and no one can touch you and you know you're not at risk of going into a sexual relationship out of wedlock it's a whole matter of control and power over women. That's why it's violence against women and girls. It's a part of that. [P56, Local Authority Employee, F]

The participant applied a victimhood narrative to describe women who undergo FGM. The body of the Muslim woman is described as a site in which violence is inflicted. The participant stated "religion has control over your body." The interviewee links Islam and FGM to argue for the need to rescue other women from oppressive religions that violate women's bodies (Rogers, 2013: 39). The perceived relationship between FGM and Islam could explain the rise of racist reactionaries to Islam. The polemic nature and ethnocentric tone of anti-FGM sentiments could stir Islamophobia (Dustin, 2010: 11) and arouse a perception of racial and cultural superiority (Gunning, 1991: 213).

A police officer also described the control of a girl and woman's sexuality as the fundamental purpose of FGM:

It's [FGM] an attempt to control a libido of a maturing woman and to prevent her from enjoying sex in the belief that she will remain faithful and I find that utterly abhorrent, they are not the values I believe in and not the values the British society believes in. [P66, Police Officer, M]

The participant describes FGM as a symbol of women's oppression and an act of resistance to Western values, as the officer states FGM is not a value "British society believes in." While previous readings of FGM viewed women as passive victims of religion and culture, the FGM

narrative is changing, as FGM is perceived as a threat to Western modernity and civilization, thus women who undergo the practice are demonised (Bilge, 2010a). This transition from narratives of victimhood to a threat to Western freedoms reflects academic work on the narratives relating to the wearing of the Islamic veil (Bilge, 2010a). Another interpretation of the quotation is that FGM can be used to justify an inflammatory discourse in a bid to liberate Muslim women (Haddad, 2007: 259). The police officer could perceive his role, as enforcing the law and upholding British values, by criminalising cultural practices. However, inflammatory language that divides FGM-performing communities and the West could have the unintended consequence of reinforcing cultural practices.

A lawyer believes that if people agree that FGM is a manifestation of control over a woman's sexuality and reproduction, then stakeholders have won the argument, albeit a simplified and reductive argument, to focus efforts on eradicating the practice:

We need to have the argument about what FGM is. What is FGM, where does it come from, because if we win the argument that FGM is a manifestation of the social control of women's sexuality and biology, you would want to have the tightest possible controls and constraints on it and if that analysis is right, to me that trumps arguments about consent and preference. Because you should not be able to opt into, or prefer a socially destructive, patriarchal, social practice, but that's the argument we need to have. [P47, Criminal Barrister, M]

According to the participant, if there is consensus that the practice is abusive to women, then there is a legitimate justification for stringent controls and constraints on FGM, even for those who attempt to undergo the practice. Stakeholders, regardless of their gender, fail to reflect on women's diverse understandings of the practice and that some women believe that FGM is not always abusive, but in fact empowering. Male and female stakeholders failed to apply an intersectional analysis to understand how black women's experiences of racism, culture, religion, nationality and marginalisation impact upon their attitudes towards FGM. Instead, stakeholders appear to believe all women from FGM-performing communities are the same and that their experiences of FGM are the same (Uccellari, 2008). Stakeholders' ignorance about FGM may be one reason for the failure to implement the law.

Conclusion and Further Analysis

This chapter has presented data and analysis of interviews with women from FGM-performing communities and stakeholders in England. The data highlights that the motivations are multifaceted. It is important to understand the motivations for FGM in order to ascertain why FGM persists in a context in which it is criminalised. The key motivations for FGM were control of girls and women's sexuality, preservation of a cultural practice, consequences of living a life uncut and religious requirements to undergo FGM. Women provided a rich understanding of their experiences of FGM, which are affected by intersectional vectors of gender, race, class, culture, nationality and religion. Women described the cultural clash they experience living in England, as they strive to continue the cultural practice of FGM to reinforce their sense of belonging. Other women believed FGM was a religious requirement in Islam and therefore defended the practice. While some women rejected the practice and described it as violence against women and girls, they still reflected upon the intersectional motivations for FGM stemming from cultural identity, nationality, religion and race. Divided attitudes towards FGM is a theme throughout the empirical chapters and in the literature review. Women's refusal to unanimously abandon FGM ensures the continuation of the practice in a context of criminalisation.

In contrast to the full body of empirical data from women, stakeholders' interview data shows a basic understanding of the motivations for FGM. Stakeholders' attitudes towards the motivations for FGM differ to women's understandings of FGM. They noted the key motivations as control of a woman's sexuality, culture, tradition and religion. Participants merely listed the motivations during interviews without critical reflection or intersectional analysis. Stakeholders held a reductive view of FGM as child abuse or violence against women and girls without considering women's experiences and understandings of the practice. While women from FGM-performing communities situated FGM within their experiences of intersectional issues of gender, race, class, nationality, culture and religion, stakeholders merely reiterated a one-dimensional view of FGM as violence. Stakeholders could be accused of peddling racist narratives that FGM is violence, which are then projected upon immigrant communities. In response, FGM-performing communities describe resisting such narratives by reinforcing the practice.

This chapter shows that FGM is not *just* about FGM. The practice also represents the defence of group rights and culture, the representation of migrant women's bodies and resistance to racist narratives. The complex meanings attributed to FGM are further reasons why the practice is impenetrable by the British state and stakeholders. Failure to understand the practice could explain why FGM persists in a context of criminalisation. Women and stakeholders were asked the same questions about motivations for FGM. The divergent view

between women and stakeholders implies the need for better understanding of FGM-performing communities' experience of race, class, culture, nationality and religion, which would assist stakeholders in combating the practice and achieving support from within communities.

Following on from addressing the motivations for the persistence of FGM in this chapter, the next chapter explores the changes in the dynamics of the practice as a result of anti-FGM laws. The question that will be explored is as follows: Having examined the motivations for FGM in this chapter, what are women's attitudes and beliefs towards the criminalisation of FGM and what impact have anti-FGM laws had on the dynamics of the practice?

Chapter Five:

The Challenges and Potential of Anti-Female Genital Mutilation Laws Eliminating the Practice: From the Perspective of Women and Stakeholders

It [FGM] shouldn't be criminalised it's her choice. When she sees that it's [vulva] open and has not been touched and she wants to really cut it, she has to be allowed.

[FG2]

Introduction

This chapter draws on women's and stakeholders' interview data to address their attitudes and beliefs towards the criminalisation of FGM and the impact such laws have had on changing the dynamics of the practice. In order to answer the overarching research question of why FGM persists in a context in which it is criminalised, it is important to understand women's and stakeholders' attitudes towards the laws and how the practice has evolved to avoid detection. The previous chapter focused on the key motivations for the persistence of FGM. This chapter explores themes of legal intervention into FGM and the changing nature of the practice as a result of anti-FGM laws. The two themes overlap and interlink. This becomes evident throughout the chapter as women's attitudes towards the law are explored and the ways in which women have adapted the practice to avoid detection and criminalisation. The research question posed in this chapter is: What are women's attitudes and beliefs towards the criminalisation of FGM and what impact have the anti-FGM laws had upon on the dynamics of the practice?

The chapter is framed by the key themes identified in the interview data. The first theme is women's attitudes as to whether FGM should be a criminal offence. This was a divisive point of discussion, particularly in focus groups. Some women supported the law while the majority rejected and criticised the law. This reflects the divergence of scholars' views in the literature review. Women's attitudes towards the law are grounded in women's experiences of intersectional issues of gender, race, class, culture, nationality and religion in the context of FGM and laws that target marginalised and racial communities.

The second theme explored is the public conceptualisation of FGM as child abuse. The majority of women rejected the label as they believed it demonised women, instead they referred to the practice as an act of love. Women's stories highlight the complex meanings of FGM for women's identities, which intersect with vectors of gender, race, culture, class and religion. These stories contrast with the reductive public and media narratives of FGM and stakeholders' monolithic view of FGM as abuse.

Finally, the shifts in the dynamics of the practice in a context of criminalisation are explored. The literature suggests that changes in the practice include taking girls abroad to be cut and cutting girls at a younger age to avoid detection (Dorkenoo, 1994; Momoh, 2005). Women and stakeholders identified other changes to the practice, which are not identified within existing literature.

I then move on to examining stakeholders' interview data focusing on their attitudes towards the criminalisation of FGM and their understanding of the changes to the dynamics of the practice. This provides a stark contrast to the findings from women's interview data. As identified in chapter four, stakeholders' reductive analysis of the motivations for FGM results in a failure to understand why the practice persists. Misunderstanding the motivations for FGM could explain why stakeholders have failed to combat the practice. It is apparent from the data in this chapter that stakeholders are aware of the changes in the dynamics of the practice. However, they are unable to use the law effectively to prosecute cases when the practice occurs underground. This could explain why the practice persists even when it is a criminal offence.

As set out in chapter four, the purpose of the empirical chapters is to give a voice to women affected by FGM rather than to project my opinions upon the analysis of the data at this stage. While the research study has an action agenda, the core purpose is an exploratory study. I therefore refrain from reaching conclusions about whether I agree or disagree with observations from the participants. In the final chapter, the conclusion, I provide a detailed interpretation, analysis and discussion of the research.

Women's Attitudes and Beliefs towards the Criminalisation of Female Genital Mutilation

Women's attitudes towards the criminalisation of FGM varied. Their attitudes depended largely on whether they supported maintaining the practice. The majority of women believed

FGM should be a criminal offence when performed on children, but not when performed on adult women:

I think it's basically the age. I don't think female circumcision is wrong unless it's done to a child because they can't consent. [FG1]

Participants argued that children cannot consent due to their age and therefore FGM should be a crime. My presence as a white woman reflecting the demographic background of law enforcement agents may have influenced their answers. I say this because interviewees did not explore any further why the practice should not be performed on children, other than providing a blanket answer that reflects public discourse: "children cannot consent."

However, there was a divergence in attitudes among a vocal minority in the focus group who believed that the law should allow parents to determine whether their child undergoes FGM:

Interviewer: Should female circumcision be a criminal offence for children whose parents consent on their behalf?

Focus group participants:

- I think it should be the same as cosmetic surgery. If it's the child who wants to get it done and they need parental consent as long as it's coming from the child.
- If you truly believe in it and you've got it done and it's your kid, then you shouldn't be penalized for it and there are not a lot of bad effects of type I. It's not like back in the days where the girl can't have kids or it will block the blood and stuff, it is just a little cut. [FG1]

The second participant in the focus group described how important it is for mothers to ensure their daughters undergo FGM. Strongly held views influenced the likelihood of women supporting FGM and rejecting the criminalisation of the practice.

Women's attitudes were polarised as to whether FGM should remain a criminal offence when performed on adult women. The majority of women argued that adult women exercise their agency and *choose* FGM. The law should not override their *choice* by defining them as victims or cultural dupes and prohibiting the practice for adults:

Interviewer: Do you think that we should criminalise adults who consent to undergo FGM?

Interviewee: I don't believe it. It's their choice. If they are an adult it's their choice. I do believe the government has the right to protect children but adults who choose that is freedom, similar to cosmetic. [P1, FGM-PCM and NGO worker, *Somalia*]

Arguing that women exercise agency to undergo FGM evokes academic theorist Meyers (2000), who argues that women exercise effective agency as accommodators of FGM. Meyers (2000) states “women who resist cultural mandates for FGC [FGM] do not necessarily enjoy greater autonomy than do those women who accommodate the practice” (469) ... “autonomy must dwell in the process of deciding, not in the nature of the action decided upon” (470). This is not a commonly found claim in the feminist literature on FGM. However, there are growing numbers of scholars arguing that women exercise agency in *choosing* FGM. Indeed, agency is not only realised when women engage in acts of resistance (Bilge, 2010a). Political scientist and anthropologist Mahmood (2011), who studied Muslim women's attainment of religious piety in Egypt, contends that women demonstrate agency in contexts of subordination because they *choose* to perform religious practices. The process of women *choosing* to participate in religious or cultural practices and then taking steps to make this a reality constitutes action. While the action may appear oppressive from a Western feminist standpoint, women make decisions based on structural and identity factors. Women's experiences of intersectional issues of gender, race, class, culture, nationality and religion all impact upon the different choices women make. In the context of FGM, the action conceived of would be organising or facilitating the practice. Participants in the focus group in London explained that FGM for adult women should be permitted because women *choose* FGM:

- It [FGM] shouldn't be criminalised it's her *choice*. When she sees that it's [vulva] open and has not been touched and she wants to really cut it, she has to be allowed.
- If people want to have FGM and they are 18 and above they want to then that's their *choice*, they have to realise the problems it's going to cause and they have to pay for it, it should not come out of the NHS pocket.
- When we are coming here to England when the child reaches 18 years they have their *choice*, their parents cannot say anything, nobody can tell them to do anything, they have their own *choice* and they are *free* to, so why this girl who is 18 years should be criminalised because she is doing her *choice*, the *choice* has been started with everything. [FG2] [Emphasis added in italics]

It appears that the participants have adopted the language of *choice* employed by the West in supporting cosmetic surgery. The language of *choice* used by participants relates to African

academic theorists who purposefully drew parallels between FGM and FGCS to highlight that Western and African women *choose* how to express their sexuality and both view the procedure as an improvement of their genitalia (Korieh, 2005). Intersectional identity vectors of gender, race, culture, class, nationality and religion determine how women from different backgrounds with different experiences choose to express their sexuality. African women may *choose* FGM, while Western women may *choose* FGCS. Women's choices are likely to be linked to their cultural backgrounds. As stated in the literature review both practices are motivated by cultural factors. While culture plays a role in women undergoing FGM or FGCS, interview participants did not use language of culture but instead opted for language of *choice*.

The language of *choice* adopted by interview participants is important. In the literature review, I drew on the work of academics Killian's (2003) and Shirazi and Mishra (2010) to highlight that Muslim women who wear the Islamic veil in the West adopted Western discourse of individual rights and freedom to support their choice to wear the veil rather than advocating a religious, cultural or communal perspective. From the empirical data, it seems women from FGM-performing communities in the West also adopted the Western rhetoric of choice and freedom to support their position rather than arguing on the basis of cultural reasons. Arguments based on religion or culture is subjective and easily dismissed by narratives of uncivilized cultural traditions oppressing women.

Similar to Western women who undergo cosmetic surgery, African women constructed themselves as exercising autonomy in changing the appearance of her genitalia to make it prettier or cleaner:

If it's anything to do with the private part, I find it [FGCS] similar because some of the people who have done FGM they find it's pretty, they say it's cleaner, I am not sure about that. The cosmetic people they say that it's much prettier than it is then there's the freedom again. I do think it's similar there's not that much difference in my opinion. [P1, FGM-PCM and NGO worker, *Somalia*]

The participant strategically linked the practice of FGM to FGCS to argue that the motivations for FGCS are the same as for FGM, to make the genitalia cleaner and prettier. Women are undergoing genital surgery for similar reasons that women undergo FGCS for example, pressures from wider society to conform to the ideal genitalia. In Western and African cultures there are cultural expectations of how a woman's genitalia should look.

Women are unlikely to be seeking FGCS or FGM for purely aesthetic reasons. The motivation that underpins both practices is cultural pressure.

As mentioned earlier in the chapter, there is a divergence in attitudes towards the criminalisation of FGM. Many women argued for the criminalisation of the practice. They believed that family and community pressures to conform to cultural expectations undermine women's consent to FGM:

There's so much pressure in the family, there's so much pressures in the community that they don't have any choice. [P9, FGM-PCM and midwife, *Mali*]

Fears of overpowering cultural pressure evoke arguments advanced by African-American academic Gunning (1999) who argues that women's agency to consent to FGM is undermined due to severe cultural and familial sanctions for not conforming to FGM. Chambers (2008) argues women's choices are constrained in oppressive contexts, which would include circumstances where women fear not undergoing FGM because they could be isolated from their family and economically deprived. This was a common theme in the interviews for arguing for the criminalisation of FGM. Having explored women's attitudes and beliefs towards the criminalisation of FGM, I now move on to examining whether women view FGM as a form of child abuse, as defined by public and political narratives, or as an act of love.

Questioning the Universal Label of Child Abuse in Defining the Practice

FGM is conceptualised as child abuse in England and Wales, which can result in the imprisonment of perpetrators and children being placed into state care away from their parents (Dustin & Phillips, 2008: 417). Dorkenoo (1994) and Momoh (2005) noted tensions and conflicts in defining FGM as child abuse. Within FGM-performing communities FGM is largely conceived of as an act of love, while the law defines FGM as child abuse. Women participants' responses highlighted their polarised views towards labelling the practice as child abuse. Before exploring the divergence in attitudes towards this label, it is first important to examine women's experiences of FGM when they were children. Women's stories of FGM when they were children evoked visceral and torturous images of FGM:

- People talk about their experience of being cut, from a young age being tortured in that way. When they can't even talk about it sometimes it can really torment.

- I have seen people who have been traumatised by the experiences they have had especially when they were giving birth or the night they got married. I have seen people like that who have talked about it and who have been affected and thinking I am not going to forgive my parents who did this. I have seen people like that. [FG1]

A woman described the flashbacks she experienced as a result of having been cut as a child and having had an active role of cutting other girls in her community:

Interviewer: Do you remember when you were cut?

Participant: Of course. I was seven. The flashbacks I am having now, it's not when they perform it to me. The flashback I am having is when I was holding the girls when they were cutting them. The screams that the girls do. I used to have it a lot. Sometimes I even scream and think there is blood all over my house, sometimes I will have the flashbacks that they are cutting someone. I used to have all the flashbacks even now. [P3, FGM-PCM, *Gambia*]

Flashbacks were a key theme of women's stories of being cut. Further research of the medical and psychological effects of living with FGM is clearly an area that needs exploring. Another woman explained that she still experiences flashbacks:

You are never going to get away from it. The flashbacks are there. You wake up, you go to sleep, you have a flashback, you wake up and you are sweating. [P12, FGM-PCM and teacher, *Somalia*]

The physical and psychological harm that women describe could constitute child abuse. Rogers (2013) contends that anti-FGM laws and child abuse terminology is less based on evidential facts but on imagined harms invoked by stories of mutilated girls (24). Scholars Werbner (2013) and Rogers (2013) argue that visions of cultural brutality being inflicted on girls reinforce racist narratives. However, there is no acknowledgment that vivid descriptions of FGM are provided by women themselves, as they outline their own stories of FGM and the impact that undergoing the practice has had upon their lives.

Having outlined women's own stories of FGM, I now move onto exploring whether women themselves define FGM as child abuse. A woman from an FGM-performing community who had not been cut defines FGM as child abuse because it involves the mutilation of healthy genitalia tissue of a child who cannot consent to the practice:

I think with children it's a form of child abuse, removing something from their bodies. If a mother decided to cut off the tip of her child's finger it would be a complete national outrage, because oh my god she mutilated her child. Whether it's her genitalia, her ear, her finger, no child should have anything removed... no one spoke about it [FGM] but now they have actually acknowledged it as a form of abuse. It has a lot to do with the language that is used to support FGM as a cultural factor but now people often use the word child abuse and that change in language has made them see it for what it was. [P8, FGM-PCM, *Somalia*]

The participant provides no critical analysis of the cultural rationale for performing FGM. Instead the participant compares the cutting of genitalia to the cutting of fingers or other parts of the body. This reductive narrative mirrors the rhetoric of wider society, policy-makers and the media that define FGM as child abuse without consideration of women's complex experiences of FGM as children and adults. Intersectional identity issues of gender, race, culture, class, nationality and religion have an impact upon women's descriptions of FGM. While women describe graphic stories of being cut, some women still refuse to define the practice as child abuse because of the cultural value inherent in the practice. Indeed, the majority of women rejected FGM upon children and yet refused to define the practice as child abuse. The reasons given for arguing that FGM as an act of love explain why the practice persists. Participants, particularly in the focus group in Leicester, explained that FGM is an act of love because families perform FGM to protect their children from social sanctions of failing to conform:

It's also seen as your kid will never get married. You don't want shame for your kid so this is sort of an act of love. You want the best for your kid at the end of the day.
[FG1]

As described by the participant in the focus group, the negative social and cultural consequences of not undergoing FGM include shame, social and cultural isolation. Fear of families being exposed to these social sanctions justifies performing FGM. Therefore not performing the practice could be regarded as child abuse. This rationale evokes African-American academic Gunning (1999), who argues that the sanctions of not conforming to a cultural and traditional practice are so severe that women could face ostracisation from their family and communities.

A woman from an FGM-performing community explained that FGM is not child abuse because they do not intend to harm the child, instead they intend to perform FGM to benefit the child:

Parents love their children and they do what they think is best and if you think my child is never going to get married and they are going to be ostracised from society and all they've got to do is go through a bit of pain for a few weeks, you do what you think is best for them. [P5, FGM-PCM, *Somalia*]

FGM is framed as a practice integral to the identity of women and FGM-performing communities. This highlights the importance of an intersectional analysis of women's experiences and understandings of FGM, as the practice is not *just* about FGM, it represents issues of cultural belonging, nationality and religion in migrant communities.

Rather than defining FGM as child abuse, women described the practice as a form of child protection and protection for the community, as it protects girls from the social sanctions of transgressing the norm of FGM. This evokes a cultural relativist argument that group rights to practice their culture should be permitted and not prohibited (Shweder, 2000). A grandmother who arranged to have her granddaughter cut explained as follows:

When I was doing [FGM] to my granddaughter I was doing [it] because I was doing it to protect her by her not been stigmatised or stereotyped by her peers. I was also protecting the family integrity and the family dignity and I was doing something good for her. [FG2]

Communities don't see it as violence, communities see it as a form of child protection because they say that if they don't protect through FGM she may then be promiscuous and she may be at risk of rape. And all these things that claim it's done to protect. If we don't do FGM we won't get married. So for quite a number of people who see it as abuse, it's actually totally different. Child abuse is premeditated and for your own sexual gratification. But for FGM it is not for individual families' gratification it is primarily done for the interests of the child. [P34, NGO worker]

The language of child protection resembles Western narratives of safeguarding children from harm and child abuse. Communities are using the same language of love and protection adopted in Western discourse to combat arguments that FGM is child abuse. Parallels can be drawn here between the appropriation of Western rhetoric of child protection and the use of

Western discourse of choice and agency to advocate for adult women *consenting* to FGM (see chapter four). Adopting Western rhetoric is strategic, as communities present their arguments *for* FGM using familiar language of the West. The use of Western language also shows that communities are aware of the arguments against FGM.

There is no evidence in the literature to show that defining FGM as child abuse changes communities' attitudes and beliefs towards FGM. The majority of women rejected the term child abuse, including women that reject the practice of FGM. Participants in the focus group in Leicester argued that child abuse is a label defined and projected onto immigrant communities by dominant Western culture:

- Interviewer: Do you think female circumcision is a form of child abuse?
- Participant: I don't believe it's child abuse. If you are looking from the outside in you'll think it's child abuse. If I look from the parent's view it's not child abuse. When I think of child abuse I think of paedophilia. I think of you know sexual abuse to young children by people who they trusted. But this is our culture. But people outside will still see it as child abuse because you didn't grow up in that kind of environment so I understand when people say it's a child abuse because you are abusing the child, you are hurting them. There's a lot of things that parents do out of love that still hurt the child. Like for me to this age I am still scared of vaccinations but they do it for my own good. You will see a lot of babies who have got their ears pierced. And there's no real health benefit to ear piercing.
- Also the child abuse is not just physical, it's to do with neglect, you know emotionally bullying the child or something, mentally, demoralizing them and everything else.
- I feel like FGM isn't what child abuse is defined as today. I think FGM is, like I said, parents wishing the best for their child. Again parents know more than the child obviously. They know that maybe there's health benefits involved. No parent today would completely mutilate their child and stitch them up.
- Child abuse is also a term people have familiarised themselves with the moment they come to like Western countries, especially in this country, no one used to use the term child abuse in our community. Whether you hit a child or you circumcise a child it wasn't child abuse.
- Our whole community who are doing this, they can't all be abusers, they can't all be crazy. [FG1]

Participants reject the label of child abuse. The term generates community hostility and resistance towards efforts to eliminate FGM. A participant in the focus group stated, “our whole community who are doing this, they can’t all be abusers, they can’t all be crazy,” which shows the normalisation and acceptability of the practice amongst communities. Participants reinforced the rights of parents to determine the cultural traditions that their child practices without state intervention, which evokes African women scholars arguments of freedom to practice culture and tradition (Ahmadu, 2000; Obiora, 1997). Scholars Shweder (2000) and Boulware-Miller (1985) argue that defining FGM as a violation of the rights of the child suggests women are abusive and barbaric, which results in marginalising communities from mainstream society and ignores their right to cultural autonomy.

While this part of the chapter is dedicated to exploring women’s attitudes towards labelling FGM as child abuse, a further theme emerged from the empirical data: women’s attitudes towards the term female genital mutilation. As women rejected the label of child abuse, they also rejected the term FGM:

It [the label ‘female genital mutilation’] escalates and demonises the community when it’s not really necessary... I feel very uncomfortable calling something mutilation and the idea of thinking a mother has taken her daughters to be mutilated. It’s very hard to digest. For an outsider it can be just seen as purely mutilation, “look what these people are doing [it’s] so barbaric”. But for an insider it’s just a small aspect of their lives that they do and move on. When a complication happens, it happens. [P7, FGM-PCM, *Somalia*]

The concern is that such labels demonise the community as described by the participant and could lead to impeding efforts to abandon FGM. This concern was highlighted by the World Health Organization in 2008, when they debated using the term FGM to define the practice due to fears of hindering social change:

“From the late 1990s the terms “female genital cutting” and “female genital mutilation/cutting” were increasingly used... The preference for this term was partly due to... some evidence that the use of that word was estranging practising communities and perhaps hindering the process of social change for the elimination of female genital mutilation” (World Health Organisation, 2008: 22).

It is clear from the interview data that labels projected onto immigrant communities by mainstream society have the unintended consequence of resulting in resistance to efforts to

eliminate FGM. The label of child abuse is ineffective in changing women's attitudes towards FGM. Instead, the label generates antipathy and resistance towards efforts that seek to encourage people to abandon FGM, including anti-FGM laws. The implicit suggestion is that communities are less likely to engage in anti-FGM campaigns because anti-FGM discourse marginalises and stigmatises perpetrators as mutilators and child abusers. This could explain why FGM persists in a context in which it is framed as child abuse and criminalised. Having examined women's attitudes to the criminalisation of FGM, I now turn to address how women have changed the practice to avoid detection from law enforcement.

Presenting the Diverse Changes in the Dynamics of Female Genital Mutilation

To address the overarching research question of why FGM persists when it is a criminal offence, it is important to examine how the dynamics of the practice have changed in order to avoid detection. The key findings from the interview data of changes towards the practice include that girls are cut abroad, they are cut at a younger age to avoid detection and the types of FGM have changed with an emphasis on types I and IV FGM, which are considered the least physically invasive types of FGM. These changes are brought about with the aim of limiting physical detection and prosecution. There is no empirical evidence in the literature of how the practice has changed to avoid legislative intervention, thus this empirical data aims to provide a contribution to the literature.

Performing Female Genital Mutilation in an International Jurisdiction outside the Purview of Law Enforcement Agents

Findings from interviews with women showed that FGM is performed in contexts which are often outside the scope of law enforcement in order to avoid detection. A survivor of FGM and midwife explained that 'cutters' (perpetrators of FGM) are flown into the UK from abroad to carry out FGM, or girls are taken from England to their country of origin during school holidays to undergo the practice:

So I do know by word of mouth it happens in the UK, in the UK definitely. We do have some people who pay for people to fly here and do that in the UK. That's the word of mouth. I do know also that most of the kids are sent back to the country mostly for summer holidays to have it done out of the UK. [P9, FGM-PCM and midwife, Mali]

Women in both focus groups confirmed that girls are usually cut in England or are returned to their country of origin for FGM. One participant in the focus group in Leicester explained that FGM is often performed in the country of origin during school holidays. Choosing to perform FGM abroad reinforces the cultural underpinning of the practice. As identified in chapter four, one of the core motivations for FGM is to reinforce a sense of cultural belonging and identity in migrant communities.

I have heard of parents taking their girls back to the country, for the home country, like for a holiday and something happens during the holiday and then they come back and they are not the same again [laughs]. [FG1]

The quotation reinforces the difficulties of enforcing anti-FGM laws when FGM is performed outside of the jurisdiction. This could explain why anti-FGM laws have not been enforced and why the practice persists.

When Medical Practitioners Covertly Perform the Practice

A surprising finding in the empirical data is that medical practitioners are key perpetrators of FGM in England:

Interviewer: Who performs female circumcision in the UK?

Participant: The black market... Or private. Some black market in some communities they do, privately [private medical practitioners] they do, privately not statutory. Practicing communities may do it like Sudan. There may be doctors who have been doing this after that because the woman needs to. [FG2]

Women confirmed that medical practitioners from FGM-performing communities perpetrate FGM. According to participants, medical stakeholders perform FGM on the black market or in private hospitals¹²¹. Stakeholders are outside of the scope of legal surveillance and law

¹²¹ News reports confirm that stakeholders have been struck off for offering to perform FGM. On 30 August 2013, a dentist was struck off by the General Dental Council for offering to perform FGM on two children following a meeting with a woman who was subsequently identified as an undercover journalist: <https://gdc-uk.org/Newsandpublications/Pressreleases/Pages/Dentist-struck-off-for-offering-to-perform-female-circumcision.aspx> [Accessed 27.12.2016]. Similarly, a doctor was struck off the

enforcement and thus can perform FGM with impunity. However, due to recent legal changes medical practitioners now have a legal duty to report cases of FGM to the police¹²². When a participant was probed about the identity of medical practitioners who perform FGM, she explained that she did not know the identity because the practice is performed with secrecy due to fears of prosecution:

They are not necessarily things that people will tell you. Now everyone knows the law, they won't tell you, "Oh I am going to cut my daughter and so and so is going to do it." It is just kept silent. To find out who does it is really difficult. [P8, FGM-PCM, *Somalia*]

Rather than eliminating FGM, increased legal surveillance can result in FGM going further underground, making it more difficult for the police. Far from reducing the incidence of FGM, punitive sanctions appear to have changed the dynamics of the practice to avoid detection.

Cutting New-born Babies as a Means of Avoiding Detection and Prosecution

Determined to preserve the cultural practice in a context in which FGM is a criminal offence, girls are now cut at a younger age to avoid detection from stakeholders who work with children. A woman explains that girls are cut a few days after birth to prevent suspicions arising:

Age has changed as well because children are going to schools and schools are being trained so what communities are doing is taking the girls as babies and they are cutting them as babies because when they come back they can't talk, they don't really know what's happened, the age has changed... the main change is the age, they are getting younger and younger. [P13, FGM-PCM and nurse, *Somalia*]

Changing the age at which children are cut has a significant impact on the meaning ascribed to the practice of FGM. FGM used to symbolise a rite of passage from childhood to adulthood, however that appears to have changed, as girls are cut when they are only a few

medical register on 30 May 2014 after a Medical Practitioners Tribunal Service panel found he offered advice on arranging FGM: <http://www.bbc.co.uk/news/uk-england-birmingham-27641431> [Accessed 27.12.2016].

¹²² They did not disclose the doctors' identities.

days old to prevent detection. Participants explained that women have changed the practice of FGM to avoid prosecution. People are negotiating their commitment to continuing the practice while ensuring that they are not criminalised. There are also other changes to the dynamics of the practice including changing the type of FGM.

Debunking Myths about the Prevalent Types of Female Genital Mutilation

The types of FGM performed by communities have also changed. Type I and IV FGM are now more likely to be performed because they are the least physically invasive and therefore less likely to be detected on a girl's genitalia. A Somali woman from an FGM-performing community and NGO worker explained that type I and IV are performed because they are difficult to detect on girls' anatomy:

So now with legislation and everything that is happening they said ok at least if we just do sunna or just prick it's difficult when I go for a physical examination to find out but this is wrong you can still find out when you've been through type I. So there might be shifts but they don't talk about it in the communities, it's taboo. Nobody will tell you I have changed my mind I don't want to do type III I will just be doing sunna. [P11, FGM-PCM and NGO worker, *Unknown*]

The difficulty in detecting type I and IV FGM on women's genitalia allows people to evade anti-FGM laws. Women are sufficiently well informed to know how to change the practice to ensure it can be maintained while preventing detection and criminalisation. However, other women argued that they had changed the type of FGM from type III to type I because type I is not a criminal offence. This highlights women's lack of education about the legal status of FGM:

The kind of practice has changed, so from being type III it is type I... it's seen that type I as not being FGM, that's another issue with the generation where type III is bad, oh no that doesn't happen, that shouldn't happen, as soon as you mention type I it is all of a sudden it's not FGM, it's just a little bit being removed. It's not a big deal it's not a crime. [P8, FGM-PCM, *Somalia*]

Women's belief that type I is legal appears to have changed the type of FGM from type III to type I. In this way, women have negotiated their commitment to performing FGM within the boundaries of the law. There are a number of ways women have changed the practice to ensure FGM continues and women are not criminalised. This is a valuable contribution to the

literature because no empirical research has explored how the practice has changed to prevent detection. Furthermore, exploring the changing dynamics of FGM has assisted in explaining why FGM continues even when it is criminalised. The second part of the chapter explores stakeholders' attitudes towards the criminalisation of FGM.

Stakeholders' Attitudes towards Anti-Female Genital Mutilation Laws

The second part of this chapter addresses stakeholders' attitudes and beliefs towards the criminalisation of FGM and their understanding of the impact of anti-FGM laws upon the dynamics of the practice. The findings contrast with women's experiences and understandings of FGM and the impact of the law. Women understand FGM through an intersectional lens, as it is representative of culture, group rights, belonging and identity. In contrast, stakeholders situate FGM within an international human rights framework because they understand it as a human rights violation and child abuse. Applying a monolithic lens rather than an intersectional perspective of FGM is one of the reasons why stakeholders struggle to understand why FGM persists. Stakeholders' lack of understanding about FGM could explain why FGM is impenetrable by the British state and law enforcement agents.

The first theme explored is stakeholders' attitudes towards the criminalisation of FGM. Unlike women who shared their diverse attitudes towards the criminalisation of FGM when performed on children and adults, stakeholders' universal condemnation of the practice justified anti-FGM laws. The second theme examined is stakeholders' attitudes and beliefs towards defining FGM as child abuse. Stakeholders who labelled FGM as child abuse were more likely to support punitive sanctions for FGM than stakeholders who highlighted concerns about projecting a harmful label upon communities. Stakeholders that cautioned against demonising communities were more likely to work at a grass-roots level with women, i.e. NGO workers. The final theme is stakeholders' understanding of the shifts in dynamics of the practice as a result of anti-FGM laws. Stakeholders' lack of knowledge about how communities have adapted the practice to avoid detection contrasts with how women say they changed the practice in part one of this chapter. The data highlights the divide between women's and stakeholders' understanding of FGM, which could explain why FGM persists even when it is criminalised.

Stakeholders Defend the Criminalisation of Female Genital Mutilation

As identified in part one of this chapter, the majority of women supported a criminal offence of FGM when performed on children. Similarly, stakeholders believed FGM should be a criminal offence for children. Women from FGM-performing communities were divided about whether FGM should be criminalised for adult women, however stakeholders believed that FGM should be a criminal offence for adult women. The reasons stakeholders gave for criminalising FGM for adults were cultural pressure and controlling women and girls' sexuality:

I think even those over the age of 18 can have pressures put on them in this regard. I think we have to agree that any form of FGM at any age, any type, is something we need to see an end of. It's a human rights violation. It's a form of violence. The reasons it's done is to control women's sexuality so even at age 18 when you are still young and still vulnerable, a woman of that age could find herself put under pressure for whatever reasons. I've spoken to survivors who have been cut age at the age of 18 or so, it doesn't make it any better it just complicates the issue if you start bringing the issue of consent into it. [P18, Civil Servant, Department of International Development, F]

The majority of stakeholders understand the practice to be a human rights violation and therefore support a universal prohibition of FGM. Stakeholders believe women's agency to consent to FGM is vitiated in a context of cultural pressure (Chambers, 2008). However, women in the first part of the chapter identified their role as accommodators of FGM and highlighted their agency in *choosing* to perform the practice (Meyers, 2000). While stakeholders argue that FGM is oppressive, they fail to recognise that issues of gender, race, class, culture, nationality and religion inform women's *different* experiences of FGM. Instead, stakeholders view FGM from a one-dimension framework that it is a human rights violation. The next theme to explore is stakeholders' attitudes and beliefs towards labelling FGM child abuse.

The Unintended Consequences of Labelling the Practice Child Abuse

FGM is defined by public policy as child abuse (Dustin & Phillips, 2008: 417). In the first part of the chapter, women were divided as to whether the practice should be labelled child abuse. Women highlighted that FGM is performed to protect and safeguard girls, thus labelling FGM as child abuse results in anger amongst communities and rejection of eradication efforts. Stakeholders were also divided about whether to define FGM as child

abuse, which shows that FGM is not universally understood as child abuse. According to a Consultant for NGOs, there is a clear demarcation between stakeholders who label FGM child abuse and those who believe FGM is an act of love:

You know there's a big division in the FGM world now. It's actually a pretty big division between the activists who say it's about making FGM legally defined as child abuse and there's others who will say, "you got to work with the community" ... people who work with social workers might say "ok it was defined as an act of love." It wasn't seen as child abuse... Bullshit. It's absolute bullshit you don't. I can tell you communities are very, very good at sharing information and if they get a consistent message across the life course of the child that FGM is illegal, if you do it we will find out, there will be a penalty and once that penalty starts to be applied I can assure you they will start to share information very, very quickly. There is absolutely no need to invest in huge amounts of community mobilisation around what is actually a very straightforward issue. It's just that it's illegal in this country. It's a form of child abuse. End of. [P58, Consultant for NGOs, F]

According to the participant, stakeholders' attitudes towards whether the practice is abusive impacts upon how they seek to implement the law. Stakeholders that understand FGM as child abuse are more likely to invoke law enforcement strategies than stakeholders who sympathise with communities' understanding of FGM as an act of love and therefore want to work with communities. The stakeholder contends that defining FGM as child abuse would clarify its status and ensure criminalisation. However, the stakeholder does not acknowledge the unintended consequences of branding marginalised communities child abusers. Women in the first part of the chapter argued that labels of child abuse stir anger and resentment in communities, as labels are projected onto them without dialogue or an understanding of the meanings of FGM (Rogers, 2013).

There was consensus amongst stakeholders that there is currently no legal mainstream response, leaving stakeholders with discretion about whether, and how, to act in cases of FGM. A lack of understanding and knowledge about FGM can leave some stakeholders paralysed into inaction. A social worker explained that stakeholders are often conflicted about whether to define FGM as child abuse due to fears of infringing people's right to practice their culture, religion and tradition:

Interviewer: Do social workers see FGM as a form of abuse?

Participant: It depends. I am sure most people would see it as abuse, but again it comes back to some stakeholders being very wary of issues involving tradition and culture. They don't want to be seen as disrespecting other people's culture and for some people it's just pure ignorance. They don't have an idea of what they go through. [P75, Social Worker, F]

The participant explains that social workers are cautious about intervening in cases of FGM due to lack of knowledge and fears of being seen as culturally insensitive. This can have the effect of girls and women being left exposed to FGM without implementing necessary safeguards. It also explains why FGM persists even when it is criminalised.

During the interviews, I probed stakeholders about why they define FGM either as child abuse or as an act of love. NGO workers were the only group of stakeholders that situated FGM within narratives that reflect women's understanding of FGM. This is perhaps not surprising given that they work closely with FGM-performing communities. An NGO worker explained that she believed FGM is performed to protect and safeguard girls:

I hope there are no prosecutions because these families are not doing it because they want to abuse their children. They do it because they try to protect their daughters. In France they have had over 100 prosecutions and it hasn't stopped anything. I don't think it's the best way forward because you are criminalising someone who is trying to protect her child. It may be harmful. I mean we talk about safeguarding but these parents are also safeguarding their daughters from being raped, from premarital sex, from being abused. They are trying to stop their daughters from being rejected by society. [P64, NGO Worker, F]

The NGO worker reiterated the same arguments as women who define FGM as an act of love in the first part of the chapter. When stakeholders work closely with FGM-performing communities they situate the practice within an intersectional context that reflects women's experiences of gender, race, culture, nationality and belonging. In contrast, stakeholders that do not work at a grass-roots level with women, but reject the label of child abuse, gave different reasons for criticising the label. A civil servant from the Department for International Development explained that in her view FGM is not child abuse:

FGM is not like child sex abuse, once it's done, it's done, it's not repeated. So I think social workers are faced with a dilemma of this child is actually otherwise in a stable loving family. Do we do more damage by potentially removing them from that

situation, where this thing is done, it's not going to be repeated. Now I can see that there is a big dilemma there... FGM is done to children because it's really believed to be in their best interests. [P18, Civil Servant, Department for International Development, F]

The participant distinguished FGM from child abuse because she viewed FGM as a single act performed in the context of a loving family unit that believe they are acting in the child's best interests. The participant reflects on women and girls' understanding of FGM, as she argues removing a child from her family due to FGM could cause further harm. Some stakeholders might be reluctant to invoke the law for fear of causing harm to the family unit. This could explain why FGM persists even when criminalised.

In contrast, the majority of stakeholders believed that FGM is child abuse. A Member of the House of Lords involved in introducing anti-FGM legislation described FGM as desecrating a child:

Interviewer: Do you define FGM as child abuse?

Participant: More than that. It's desecrating a child in some way, which is just unacceptable. If you are talking about child abuse a few years ago you would be talking about paedophiles. But you really want to talk about the physical cutting of the child, very much perpetrated for the men's expectation of that particular woman when she grows up, so it's much deeper to me than simply child abuse. It's not an act of love, never can be an act of love. The child does not have a choice. I refuse to accept it. [P27, Member of the House of Lords, M]

The participant's quote reinforces academic Rogers (2013) arguments that politicians used visceral language to evoke images of mutilated children in order to pass anti-FGM legislation. The British state's interest in FGM ensures the enforcement of British values. Anti-FGM narratives had the effect of portraying FGM-performing communities as uncivilised child abusers (Winter, 1994). The monolithic understanding of FGM demonstrated by stakeholders shows a stark contrast in women's experiences of the practice in part one of this chapter.

All of the stakeholders interviewed defined the practice as violence against women and girls because they believe the core motivation for FGM is to control girls and women's sexuality as highlighted in the previous empirical chapter on motivations for FGM. A teacher who works with girls who have undergone FGM, describes the practice as violence against women and girls rather than child abuse:

It's [FGM] violence against women and girls. It's to do with the belief that a girl's chastity, her body, is not entirely her own. Her value is entirely linked to her purity, or so-called purity and it's taking away her right to make decisions about her own body and her own sexuality and her own right to enjoying sex... It has to be treated like any other form of abuse, any other offence. It is an offence, it is child abuse, it is grievous bodily harm. I think it is a form of sexual abuse... I think it is essential it is prosecuted. It's almost like we are having conversations about FGM that we had about sexual abuse 30 years ago. [P78, Teacher, F]

The stakeholder explores the cultural rationale for performing FGM, as it is linked to notions of purity and control of girls and women's sexuality. Defining FGM as cultural violence highlights the juxtaposition of Western civilisation as superseding culture. In the West women and girls are portrayed as making autonomous choices about their sexuality free from cultural constraints. Any attempt to infringe women's freedom is met with the introduction of prohibition.

While some stakeholders defined FGM as child abuse or violence against women and girls, other stakeholders specifically defined FGM as honour-based violence. A Crown Prosecution Service lawyer explained that control over a girl's sexuality from childhood through to adulthood indicates that the practice is a form of honour-based violence:

The nature of the offending [in performing FGM] is, you are going to have girls whose sexuality is controlled. They are going to be coming from the sort of families where they could end up in a forced marriage, or face other honour based abuse... If you are from a family that performs FGM, you know that the practice is performed to control your sexuality, to improve your marriageability. There are bound to be other honour-based controls in that family. [P68, Crown Prosecution Service, F]

The participant explains that FGM is performed to control a girl and woman's marriageability and reproduction. It was rare that stakeholders defined the practice as honour-based violence. However, concerns about honour-based violence reflect government policy and dialogue about other so-called Islamic practices of wearing the Islamic veil, child marriage and forced marriage (Dustin & Phillips, 2008). The Government treats these practices with suspicion because their public presence challenges the British way of life, which justifies prohibition.

In the first part of the chapter, women explained that labelling the practice child abuse or even mutilation has the unintended consequence of women resisting efforts to eliminate the practice and even reinforcing the practice. Stakeholders are aware of the hostility of community members towards labelling FGM as child abuse. According to an NGO worker that works closely with women, defining the practice child abuse can result in community members resisting engagement with stakeholders:

The publicity has done more damage than any good for the victims because now the communities don't want to talk to us. They don't want us to go to work to do anything with them. Because we are calling them barbaric, we are calling them inhumane and we forget that older women are victims of this practice. We forget that they also suffer. By saying they are barbaric and abusing their children, they get really angry. It hasn't been any help at all. [P64, NGO Worker, F]

The stakeholder shows an acute awareness that women resist the label of child abuse because they believe it stigmatises and targets them as barbaric mothers (Boulware-Miller, 1985; Shweder, 2000). This reaffirms the concern raised by academic Rogers (2013) that portraying mothers as mutilators will alienate women rather than changing their attitudes and beliefs towards FGM.

Child abuse was not the only label to rouse hostility. As identified in the first part of the chapter, labelling the practice mutilation evoked anger amongst women (World Health Organisation, 2008: 22). Language and labels have a key role in determining how the practice is understood and legislated. Recognising the backlash stakeholders might encounter for labelling the practice mutilation in the 1980s, politicians defined it as female circumcision because it reflects the language used by women:

Mutilation just wasn't going to be acceptable. Too harsh a word. There was a lot of lobbying from the host communities because they didn't like the word mutilation because they said we are not savages we don't mutilate our children, you know. So it's like if you use the word barbaric practice that sort of puts the host communities on the back. We are not barbaric. [P29, London Assembly Member, F]

Lobbying from FGM-performing communities appears to have been effective in preventing the term mutilation from being used in the 1980s. Since then there has been a change in language and discourse in framing the practice as mutilation and child abuse. One reason for

the change in lexis is to clarify that the practice is not tolerated and to encourage stakeholders to refer cases to the police:

I think we have gone away from looking at FGM as circumcision, we are using a completely different word about it which suggests to me it is the amputation that is involved with type I, II and III, is what people find objectionable. [P51, Lawyer, M]

According to the lawyer labelling the practice mutilation symbolises that it must be criminalised. The language of mutilation also creates a monolithic narrative that is simplistic and easily understood by the public. Language is key to identifying how stakeholders understand the practice and seek to legislate. While hyperbole language and narratives reflect the objective of prohibiting FGM, they have the unintended consequence of communities rejecting efforts to eliminate FGM thereby reinforcing the practice. This is a further reason why FGM persists even when the practice is criminalised. The final theme addressed in this chapter is stakeholders' understandings of the changes in the dynamics of the practice, which compare and contrast with women's experiences of changing the practice to avoid detection.

How the Changing Dynamics of Female Genital Mutilation Drive it Underground

As highlighted in the first part of the chapter, which presented the interview data of women, communities have adapted the practice of FGM to avoid detection and prosecution. Stakeholders demonstrated an understanding of how women have changed FGM to avoid detection. Stakeholders identified the following key changes to the dynamics of FGM: girls are cut younger, FGM is performed abroad and the types of FGM performed have changed to type I and IV, which are believed to be the less physically invasive types of FGM, all to avoid detection. The changes identified by stakeholders reflect the same changes described by women, which suggests a good understanding of FGM. The changes identified are barriers to the enforcement of anti-FGM legislation, which is discussed further in the next empirical chapter.

Cutting Girls Younger Avoids Scrutiny

A key change to the practice that stakeholders noted is that girls are cut younger. An NGO worker that supports FGM-performing communities in community engagement projects

explained that children are being cut when they are babies to avoid detection when they commence school:

Anecdotally, we are told that the child affected by FGM are becoming younger, so the hypothesis has been since criminalising FGM... Families have been performing FGM at a younger age to avoid the scrutiny that they come under in school. [P57, NSPCC, F]

The quotation shows that stakeholders are aware that the practice has gone underground to avoid detection. The difficulty is that stakeholders are unable to detect FGM when performed on young girls. A police officer explains the barriers to enforcing anti-FGM law when children are cut as babies:

If you put yourself in the position of the child most children get this done when they are very young. Most children won't know they've got it done. They will regard it as natural. They won't compare their anatomy with others. If they are aware they might think this is how it is. They will have heard from parents that it was done with the best of intentions really and in their long-term interests. So the chances of a child coming forward and testifying in the first instance, which means giving evidence to the police against the parents is never going to happen. [P66, Police Officer, M]

In reality, children who are cut as babies will be unaware FGM has been performed. When children are informed of FGM, parents are likely to explain the cultural rationale for FGM. As argued by Dustin and Phillips (2008), prosecuting cases of FGM raises nuanced problems that do not exist for other crimes, namely that the offender is likely to be a parent or relative of a victim who is unlikely to perceive them as criminals (417). In this context, the law is unable to penetrate the practice and prevent FGM. I will now move onto exploring the law's limited role in preventing FGM when it is performed in an international context.

The Evidential Challenges of Prosecuting the Practice when Performed Abroad

A further barrier to implementing the law is that FGM is often performed abroad. As a police officer explains when FGM is performed outside of the jurisdiction of England and Wales, the police struggle to gather evidence against perpetrators:

It's a lot to do with gathering the evidence and actually getting people prepared to give evidence and to actually go to court is the main reason. And also FGM is being

performed abroad and places like that. It is probably a difficulty. It is really just evidential difficulties in knowing who to charge and it's just the families really refusing to give details. [P66, Police Officer, M]

Communities work together to ensure the practice is maintained without scrutiny from stakeholders, therefore gaining evidence from witnesses is a challenging task. An NGO worker who works closely with women from FGM-performing communities explained that FGM is performed on girls and women in jurisdictions where the practice is medicalised and legal, for example Dubai:

We have certainly heard in Dubai that UK customers are their top customers for FGM. I'm sure there's other markets. In Dubai it's not illegal, it's a big holiday destination for Muslim people ... I was at the airport operations a couple of times. Airport operation limelight, project Azure runs them with a couple of survivors who campaign, so they target countries with high prevalence of FGM ... There's loads of police officers and survivors together talking to people on their way out [of England] and asking people about FGM. We identified at least one case, when I was there, one case of a trafficked girl and then there was another woman from Sierra Leone and she had with her the traditional stuff they use for the cutting celebrations, so she was stopped. I don't think they could prove anything. It would have been impossible to prove. [P59, NGO Worker, F]

The NGO worker describes an initiative known as Operation Limelight run by Project Azure, which is part of the metropolitan police. The police and survivors speak with FGM-performing community members at the airport who are intending to travel abroad. While this initiative could raise awareness and deter the practice, there is no evidence to measure the efficacy of the initiative. Even when the police identified girls at risk of FGM there were difficulties in gathering evidence against perpetrators to allow for a prosecution. A further challenge for stakeholders is identifying that a girl has been cut on return from abroad. Medical examinations are not permitted without parents' consent, as explained by a doctor who specialises in FGM:

If children are taken home to be cut and returned to the UK that's a criminal offence... the difficulty is that you can't examine them when they come back in again without the parents' consent otherwise it's an assault. [P43, Doctor, F]

While stakeholders are aware of the changing dynamics of the practice of FGM, the law is not an effective tool in preventing the practice and prosecuting perpetrators. The practice is able to continue underground without detection by stakeholders. Having explored the international context of FGM, I will now proceed to address the role of medical practitioners in performing FGM underground.

Medical Practitioners by Day and Cutters by Night

Findings from the interviews with stakeholders show they are aware that medical practitioners are performing FGM underground. A former midwife explained her experience of a surgeon deinfibulating and reinfibulating his wife in a hospital in England and Wales in the early 1990s:

There have always had to be medics doing that [FGM]. You know, there was a consultant who allowed his registrar use of theatre time, use of a bed, when I met my first face-to-face survivor in this country and thought nothing of it. The registrar was Egyptian. He brought his wife to de-infibulate for the birth of the baby and then to re-infibulate in hospital. He thought nothing of it. The theatre staff thought nothing of it. I was the only one who responded, because I responded in such a dramatic fashion everybody said oh this can't be right, it can't be right because a surgeon cannot operate on his wife, [laughs] that was the first response, that was the first breach that they were concerned about. So if it had of been any other surgeon he would have just said to me "oh shut up you silly girl this is a surgical matter." [P29, London Assembly Member, F]

Although the case referred to above occurred in the early 1990s, the practice was a criminal offence. There are still reports of FGM being performed by doctors in England today. A local authority employee who works with women at a grass-roots level explains that communities pay medical practitioners to perform FGM in England:

You've got communities paying medical practitioners. Paying them off, making a quick buck on the side, it's disgusting ... You've got two key figures that are in a position of trust, you've got your parents who you implicitly trust anyway and then you've got a doctor who you'd always trust as they are a doctor, wouldn't you ... A child would think, mum and dad aren't going to hurt me, the doctor isn't going to hurt me. [P20, Local Authority Employee, F]

The stakeholder identifies perpetrators of FGM, as medical practitioners and parents. In such circumstances girls are likely to believe the practice is acceptable, as medical practitioners and parents will be perceived by girls as professionals in positions of trust. While medical practitioners were accused of performing FGM, they were also identified as a group of stakeholders that conceal information about FGM rather than refer cases to the police. According to an NGO consultant, doctors are the most likely group of stakeholders to meet with girls at risk of FGM and survivors of the practice, yet they refuse to refer cases to the police:

They [medical practitioners] have totally failed to report it. You can talk to the police and they will tell you that, exactly that... They [police] were simply not getting any cases through. And then the NSPCC did that massive study in London finding out how many women with FGM had been diagnosed in clinic services and it was massive, huge amounts, 2000 women, one of whom was 12, there was a 12-year-old who had been diagnosed with FGM no follow up, no reporting, nothing. So they have totally failed to report. [P58, NGO Consultant, F]

Medical practitioners explained that there are a number of reasons they do not report cases of FGM, namely patient confidentiality, lack of training about FGM, a belief that punitive sanctions will not eliminate the practice and a desire to work with communities to change attitudes and beliefs. Medical practitioners appeared confused about when and how to report cases of FGM. They argued that they needed clear guidance of when and how to act. This could leave girls at risk of FGM vulnerable to the practice without safeguards in place. The Serious Crime Act 2015 recently introduced mandatory reporting for medical practitioners in cases where a girl under the age of 18 has been subjected to FGM. Further research is required in the future to ascertain the impact of the law upon medical practitioners' attitudes towards cases of FGM. I will now move onto exploring the final change to FGM that stakeholders identified, which was a change in the type of FGM performed.

Changing the Types of Female Genital Mutilation to Prevent Detection

Women in part one of this chapter stated that they had changed the type of FGM to type I and IV, which are the least physically invasive types of FGM to prevent detection by medical practitioners and thus prosecution. Other women stated that they performed type I FGM, as they were under the misapprehension it is a legal. Stakeholders are aware that communities believe type I is legal. An employee of a Police and Crime Commissioner explained communities' lack of understanding that type I is a criminal offence:

A mixture of responses in relation to type I as well. In one of the groups that I attended where there was the 35 women. The one group that was saying yes it is illegal and you shouldn't do it. The other group were saying it's absolutely fine. The middle group, 10 women, they were the ones saying well it's alright if it's only type I because it's just a pin prick so that's ok. [P67, Employee of Police and Crime Commissioner, F]

The police officer's belief that communities are unaware type I is a criminal offence accurately reflects the interview data of women in part one of the chapter. A key obstacle to eliminating FGM is that communities continue to practice type I FGM, as they do not regard it as FGM. Other community members are aware type I is a criminal offence but continue to perform it because it is difficult for stakeholders to detect that a girl has undergone type I. A consultant gynaecologist and obstetrician explains the obstacles in identifying type I by physical examination:

I have been working with people with FGM for 30 years and even I sometimes look at a vulva and think has this undergone FGM or has she just got a small labia I don't know. It might be type I or type IV, or it might be a variant because vulvas are enormously variable. [P40, Consultant Obstetrician and Gynaecologist, F]

As identified in the first part of the chapter, community members are aware of the difficulties in detecting type I and type IV therefore they have changed the type of FGM to the least physically invasive to prevent prosecution. Recognising the challenges of communities abandoning FGM altogether, an NGO worker described a lobby who argue that the law should permit the least physically invasive types of FGM as a form of harm reduction:

There have been people who have criticised me for saying it should be stamped out immediately. What they do say is that the mildest form of FGM should continue to happen because it would take too long for them to part ways with it altogether. [P65, NGO Worker, F]

Calls for 'harm reduction' in the form of inflicting the least physically severe types of FGM on girls have come from the *The Economist* (18 June 2016) and academics Arora and Jacobs (2016). They argue that a blanket ban of FGM has not eliminated FGM therefore a new approach is required. Arora and Jacobs (2016) argued that type IV FGM is less physically harmful than male circumcision and therefore should not be prohibited on medical grounds.

Harm reduction strategies have been a source of discussion amongst scholars in the past. Indeed, symbolic circumcision otherwise known as type IV FGM is still highly controversial but it has been proposed as an alternative to more severe forms of cutting in both African and other countries where FGM is performed (Coleman, 1998; Obiora, 1997; Pediatrics, 2010; Unicef, 2013). The World Health Organisation (2008) argues that allowing the mildest form of FGM to be performed legitimises the mutilation of girls and women's genitalia for non-medical purposes and could serve to push back efforts to eliminate FGM altogether.

A publicised case in January 2016 of type IV FGM involved the pricking of the clitoris of a British baby of Malaysian descent who was allegedly taken abroad to undergo the procedure at only a few months old¹²³. The CPS decided not to prosecute the parents because "there is insufficient evidence to prove FGM... due to a lack of medical evidence of anything that could fall within the definition of FGM."¹²⁴ Cases of type IV FGM are likely to become more prevalent as this type of FGM is performed to avoid detection and prosecution. In 2016 there was a landmark FGM case in Supreme Court New South Wales in Australia¹²⁵ that resulted in the conviction of a mother, midwife and Imam from the Dawoodi Bohra sect of Islam for performing type IV FGM. The jury rejected the defence case that type IV was "purely symbolic and inflicted no injury." In Detroit, Michigan four members of the Dawoodi Bohra sect of Islam have been indicted on charges of FGM, which is reported as type IV¹²⁶. This is the first time the US government has prosecuted an FGM case since federal law was passed in 1996. The case is still on going and subject to extensive media scrutiny.

Conclusion and Further Analysis

This chapter outlined the data and analysis of interviews with women from FGM-performing communities and stakeholders about their attitudes towards the criminalisation of FGM. The data shows that women were divided in their attitudes and beliefs towards the criminalisation of FGM. Women's attitudes towards criminalisation of the practice were situated within their experience of FGM. Women who supported the practice were more likely to resist

¹²³ See <https://www.standard.co.uk/news/crime/baby-fgm-court-case-thrown-out-due-to-lack-of-proof-a3159056.html> [accessed 27.08.2017]

¹²⁴ *Ibid.*

¹²⁵ See judgment of Mr Justice Johnson in *R v A2; R v Magennis; R v Vaziri (No 23)* [2016] NSWSC 282 and Rogers (2016).

¹²⁶ See <http://quillette.com/2017/08/15/female-genital-mutilation-health-benefits-problem-medicalizing-morality/> [accessed 27.08.2017].

criminalisation of the practice. For many women FGM resembled more than the practice it also represented their cultural roots, identity and religion and therefore attempts to prosecute perpetrators were met with resistance. The second theme explored was whether women label FGM child abuse or an act of love. The majority of women rejected the label of child abuse, which they argued demonised community members as barbaric parents (Rogers, 2013). The label had the unintended consequence of communities resisting initiatives to eradicate FGM and even reinforcing the practice. Finally, women highlighted how they negotiated their commitment to continuing FGM in a context of criminalisation, namely by changing the dynamics of the practice to avoid detection and prosecution.

The second part of the chapter explored stakeholders' attitudes and beliefs towards criminalisation of FGM and their understanding of how women have changed the practice to avoid detection. This provides a sharp contrast to women's attitudes. Stakeholders supported the criminalisation of FGM as they situated the practice within a human rights framework. The majority of stakeholders also adopted the label of child abuse to define FGM. Stakeholders failed to reflect on how women's understandings of FGM are informed by their experiences of intersectional issues of gender, race, class, culture, nationality and religion. Recognising the multiple and complex experiences of women towards FGM could assist stakeholders in understanding that criminalising FGM and labelling it child abuse could have the unintended consequence of reinforcing the practice rather than eliminating it. Finally, stakeholders understood how communities have adapted the practice to avoid detection. However, they were unable to implement the law in these new circumstances because the practice had gone further underground.

It is clear from the interviews that women's and stakeholders' attitudes and beliefs towards the criminalisation of FGM are varied and impact on whether, and how, the law is implemented. Failure to understand communities' hostility to anti-FGM laws could explain the challenges in eliminating the practice. The next chapter focuses on the barriers that prevent the laws being implemented from the perspective of women and stakeholders. The question that will be explored is as follows: What are the barriers to anti-FGM laws functioning effectively in eliminating FGM?

Chapter Six:

The Barriers to Anti-Female Genital Mutilation Laws Deterring and Preventing Female Genital Mutilation

I know one girl at secondary school and at PE [sports class at school] she was held down by two girls and they tried to take down her trousers. It's like they are a freak show.

[P5, FGM-PCM, *Somalia*]

Introduction

This chapter explores the barriers to anti-FGM laws functioning effectively in deterring and preventing FGM. The conclusions of this chapter assist in answering the overarching research question of why FGM persists when the practice is a criminal offence. The focus of this chapter is on the barriers to anti-FGM laws from the perspective of women from FGM-performing communities and stakeholders responsible for designing and implementing the law and working directly with communities.

The first part of the chapter explores what women believe are the barriers preventing the laws from operating effectively. The second part of the chapter examines stakeholders' beliefs towards the barriers preventing the law from being effectively enforced. The first barrier addressed is education. Many women were unaware that FGM is a criminal offence. This reflects the marginalisation of FGM-performing communities from a political and democratic system that is responsible for designing and implementing the law. In contrast, stakeholders were unaware of women's lack of knowledge of anti-FGM laws. Furthermore, stakeholders also suffered from a lack of education about FGM and struggled to respond to child protection cases adequately.

The second barrier explored is women's reluctance to use the criminal justice system to deal with cases of FGM because of their experiences of structural racism and sexism through the law. Women argued that public and political anti-FGM narratives alienate communities because they cannot identify with labels of barbarism and child abuse. Instead, hyperbole rhetoric serves anti-immigration agendas. Women's attitudes towards the legal barriers must

be situated within an intersectional analysis of how their experiences of legal discrimination on grounds of gender, culture, race and religion impact upon their attitudes towards anti-FGM laws. In contrast, stakeholders lacked knowledge of why women fear accessing the criminal justice system, as a result they struggled to respond appropriately to communities to encourage them to work with law enforcement agents. Instead, stakeholders describe their fears of acting in cases of FGM due to concerns that they could be branded as racist.

The final barrier examined is the perceived double standard of the law in permitting FGCS while outlawing FGM. This example of legal hypocrisy roused anger amongst FGM-performing communities and provided women with further ammunition for defending the right to practice FGM. The majority of stakeholders rejected the assumption that there is a legal double standard. In doing so, they failed to acknowledge that the legal double standard might be a barrier to the enforcement of anti-FGM laws.

Women's Attitudes to the Barriers Preventing Anti-Female Genital Mutilation Laws Working in Practice

Education, Education, Education

The majority of women believed that a key barrier to implementing legislation was lack of education about FGM and anti-FGM laws within FGM-performing communities. Some women claim the practice is not discussed within families or communities publicly. The practice is embedded in secrecy and taboo (Akers, 1994). Even when FGM is discussed, it is not challenged (Hosken, 1979). The following quotation from an FGM-performing community member who was not cut reveals how she shattered taboos by discussing FGM and educating girls at school:

For me I couldn't understand why coming from a Somali background I had never heard of the practice before. No one wants to talk about it, no one wants to talk about it in the Somali community, no one wants to talk about it outside, no one wants to talk about it at government and policy level... I know one of the main reason why girls in my year group and the year above and below me discussed FGM was because we kind of made it normal to discuss FGM. It lost that kind of cultural fear. It's a shame to talk about it. [P8, FGM-PCM, *Somalia*]

Education is one way of working towards the eradication of FGM, as it moves the practice from the private to the public. Feminist movements have worked for decades to bring the private into the public, to make the personal political (Bunch, 1990; MacKinnon, 1989). A survivor of FGM and teacher explains that education is imperative, as her mother performed FGM because she was not educated about the consequences of the practice:

It's [FGM is performed] out of ignorance, lack of education, it's out of a lot of things and it's merely cultural. Culture is like a cancer you can't take it out. It's too hard to take it out. [P12, FGM-PCM and teacher, *Somalia*]

The participant highlights the difficulties of changing cultural traditions, which are deeply rooted and embedded. The interview data shows that relying solely on the law to change attitudes and beliefs is unlikely to result in the abandonment of FGM. The law cannot change attitudes and beliefs if communities are unaware of the law. Lack of awareness of anti-FGM laws could be a contributing factor to the persistence of FGM even when it is a criminal offence. During the focus groups, participants' lack of education about the status of the law became apparent as they asked me for clarification of the legal status of FGM:

We are saying there should be more awareness from the government rather than penalizing the people because some of them are not aware of even whether type I is illegal. They think only type III is illegal and some of them don't even know what FGM is. [FG1]

The interview data shows that lack of education about FGM and anti-FGM laws is a key factor to laws not functioning effectively in eliminating FGM. Having listened to the voices of women, it appears that the marginalisation of FGM-performing communities from mainstream society means there is a gap between legislation on the statute book and communities' understanding of the law. It seems the government has not prioritised and invested in education at a grass-roots level. Having explored lack of education as a barrier to eliminating FGM, I will now move onto examining racial tensions and racism as a barrier to the law preventing and deterring FGM.

Racism: The Unspeakable Barrier to Anti-Female Genital Mutilation Laws Working Effectively

I consider how the experiences of ethnic minority women are frequently the product of intersecting patterns of structural racism and sexism and how these experiences deter women from relying upon the criminal justice system (Crenshaw, 1991). Participants rarely discussed or gave examples of racism that they had personally encountered in the context of FGM or discrimination through the law. Only one participant gave an example of direct racism stemming from FGM. Pupils at a school tried to pull a girl's trousers down to see if she had undergone FGM.

My cousins who are in secondary school already get teased about it [FGM] anyways. Everyone wants to know if they've been cut and how it looks and they haven't [had FGM] they were born in England. I know one girl at secondary school and at PE [sports class at school] she was held down by two girls and they tried to take down her trousers. It's like they are a freak show. [P5, FGM-PCM, *Somalia*]

The traumatic experience the young girl encountered at school stems from racism and possibly Islamophobia. Popular discourse about the heinous sight of cut vulvas can determine the nature of response to FGM. The story relates to an example of Islamophobia featured in a UK report, '*Measuring Anti-Muslim Attacks*,' where "a Muslim schoolgirl had her hijab forcibly pulled from her head by the parents of another child at the same school while a crowd of onlookers were looking on and laughing" (Allen et al., 2013: 8). From wearing the Islamic veil to being cut, these practices are visible markers of girls and women's difference. The hostility girls and women encounter as a result of FGM may make them less inclined to seek support from service providers. This could serve as a barrier to women accessing the criminal justice system.

A key example of racial tensions is the fraught relationship between the police and FGM-performing communities. As Crenshaw (1991) argues, women's race, gender and cultural identity affects the likelihood of women seeking support from the police (1250). FGM is a unique offence, as it is a crime directed by the dominant class towards ethnic minority communities (Winter, 1994: 940). This inevitably invokes debates of race, cultural diversity and the status of immigrants. In the interviews, women linked anti-FGM laws to broader structures of racism and structural oppression stemming from law and policy that is enforced upon women in the face of community objection (Menjívar & Salcido, 2002: 900; Rogers, 2013). A quotation from an FGM-performing community member encapsulates the hostility community members feel towards the police:

I think because the police are always received with a lot of suspicion. I don't know how much work the police can accomplish. I don't think the police is a good kind of candidate to get involved [with cases of FGM]. [P7, FGM-PGM, *Somalia*]

Anti-FGM laws have resulted in communities distancing themselves from law enforcement agents. Women are fearful of state intrusion into the lives of marginalised communities, as it can exacerbate the disempowerment of those already subordinated by the structures of domination (Crenshaw, 1991). The participant's comment that "the police is not a good kind of candidate to get involved" exemplifies women's feelings of ambivalence about using the police to deal with FGM (Sokoloff & Dupont, 2005). A woman from an FGM-performing community argues that policing of FGM translates into surveillance of immigrant communities:

When people say police working closely [with communities], black people are so heavily policed already I don't understand how much closer they can get. Once people in our community know that the police are watching them, they keep away from them and keep themselves to themselves. [P5, FGM-PCM, *Somalia*]

The quotation from the participant relates to critical race theorist debates, as scholars argue that the overreliance on law enforcement to deal with social problems in ethnic minority communities has unintended consequences including increased surveillance, use of force, mass incarceration and police brutality (Sokoloff & Dupont, 2005). The result is that FGM-performing communities refuse to engage with law enforcement agents for fear of racist reprisals. This is a further barrier to the law preventing and deterring FGM.

An FGM-performing community member spoke in detail about the impact the failed prosecution of FGM in 2015 had upon the woman complainant. This was a unique prosecution as it was pursued without the support of the complainant. The complainant even gave evidence on behalf of the defence in support of the defendants: her former doctor and her husband.

Interviewer: What effect do you think prosecutions will have on FGM?

Participant: Probably close down conversation. We all know who the lady is who they tried to prosecute her husband, everybody knows all the stress she went through, she lost loads of weight, she was really upset, she became depressed because she just gave birth and she had a small child. Her husband is up on charges and it was hanging over her head for a really long time even though it only took half an hour for them to

say not guilty. So there was all this lead up and she felt all this pressure to be a witness. I don't know anyone who would be willing to talk to the police. And everybody knows who she is even though she didn't have her name in the press, everybody knows who she is ... everyone knows everyone's business. [P5, FGM-PCM, *Somalia*]

Women are usually presented as victims of FGM (Dustin & Phillips, 2008). However, women who refuse to cooperate with law enforcement agents could be depicted as a threat to Western civilisation and women's freedom. The impact of women's refusal to cooperate is particularly relevant here, as an analogy can be drawn with veiled women, who were initially portrayed as victims of Islam and later as dangerous threats to the West when they adopted the veil as a personal and political choice (Bilge, 2010a; Haddad, 2007; Khiabany & Williamson, 2008: 83). It is evident from the voices of women that the enforcement of cultural changes through the law is rarely successful and more often dangerous (Marranci, 2004). Rather than changing cultural practices, the law could have the opposite effect, as communities oppose and resist the law by reinforcing the practice. Women's resistance to anti-FGM laws is explored in the next section of this chapter. I examine women's attitudes and beliefs towards the legal double standard of permitting FGCS while permitting FGM.

The Legal Double Standard of Criminalising Female Genital Mutilation while Permitting Female Genital Cosmetic Surgery

There is a volume of literature debating the double standard in law that permits FGCS while criminalising FGM (Dustin & Phillips, 2008: 414; Pedwell, 2007). While scholars have debated the legal double standard from a theoretical perspective, few academics have considered whether this has impacted upon women's attitudes and beliefs towards anti-FGM laws. Findings from the two focus groups showed that women who support FGM strategically linked FGM and FGCS as comparable practices. By connecting the practices, participants in the focus group advocated for the decriminalisation and the medicalisation of FGM:

- If a woman volunteers that she wants female circumcision, I think that's her choice the same way cosmetic surgery is her choice. If it's on a child either of them it's wrong. But if it's a woman who over the age of 18 wants to get this done for her own reasons I don't see the problem with it.
- I agree. If they want to put silicon pads in the foreheads or in their arms that's up to them because it's choice.

- I think you should implement the same laws as plastic surgery, so it's your choice. If you want it. Obviously give her a few pamphlets and an introduction on the side effects.
- I don't think it's [FGM] different to any plastic surgery as long as you are the age of consent you should be able to do everything and anything. [FG1]

Similar to the women in the focus groups, African women scholars connected FGM and FGCS as a means of arguing for the equal treatment of the practices (Korieh, 2005). One of the key arguments in the focus groups and in the literature for linking the practices is consent: if women in the West have a right to express their sexuality and undergo FGCS then African women should have the same right to choose FGM (Korieh, 2005). There is a dearth of literature exploring whether women have adopted the language of individual choice to argue for FGM. However, there is ample research exploring Muslim immigrant women in the West who have adopted the Islamic veil and use “a Western discourse of individual rights and personal freedom to justify their position” (Shirazi & Mishra, 2010: 58-59). Findings from the focus groups show that women advocating for FGM also adopted a Western discourse of rights and freedom. Permitting FGCS while prohibiting FGM could be a barrier to anti-FGM laws preventing and deterring FGM. Instead, the legal double standard could justify the defence of FGM and encourage resistance to anti-FGM laws.

Rather than the law deterring and eliminating FGM, the law could offer a means of continuing FGM under the guise of FGCS. There is no discussion in the literature of whether women are undergoing FGM under the guise of FGCS. In the second focus group, one 18-year-old Somali-born woman explained that two friends also from Somalia underwent FGM under the guise of FGCS in England before they married:

Participant: My generation because they can't practise female circumcision, female cutting, they consider other avenues like cosmetic surgery of the vagina. The younger generation are not happy with the shape of it, that's the thing. I don't really talk to them in that explicit language. I have friends of mine who were going to get married and they said they were not happy with how it looks so they were trying to find other ways they could enhance it. They just want it to look better because we, they are from Somalia and they are worried they have a large clitoris or something like that. So they have to get it done because they [their husbands] will see and if they go down the FGM avenues they can get negative conditions [illegal]. I have two friends who have done it. I don't know [whether it was NHS or private]. They didn't do it outside [the UK].

Interviewer: Was it the labia or the clitoris [that was cut]?

I am not sure they just told me they got it done. I wasn't aware. They are in the 30s, they don't live with their mum and they are getting married.

Interviewer: Why don't they have FGM instead?

Participant: Because it's not the same I think. Anaesthetic. They will have anaesthetic. I think it's different than the FGM but it's not good. They weren't happy with how it looks for cosmetic reasons. But that's also abuse if it would be done to a young person. [FG2]

The implicit suggestion in this account is that two African women have exercised their agency and autonomy and made an empowered choice to undergo FGCS. Undergoing FGCS enabled them to evade anti-FGM laws. The participant does not mention culture as a reason for undergoing the surgery. In reality, both practices emanate from cultural pressures in the West and Africa. However, the participant adopted Western discourse of choice arguing that the surgery was performed to make the genitalia "look better" or "enhance it." The language of the beauty industry has been co-opted by performers of FGM as a means of legitimising the practice.

The discourse of *choice* used to advocate for FGM reflects the findings of academic Killian (2003) in a study on veiling in France. Killian (2003) found that younger educated Muslim women view the Islamic veil "as a matter of personal liberty and cultural expression," adopting the language of Western discourse (567). The language of the participant reflects Western discourse, as she advocates for the enhancement of the genitalia. Adult African women are characterised by the participant, as exercising effective agency in performing FGM under the guise of FGCS. They navigate the legal system to continue FGM. Rather than deterring and preventing FGM, the law has given women a means of performing FGM in a legal context.

The findings from the empirical data show that women are well informed of the legal double standard. The legal double standard roused anger and frustration amongst community members in the focus group. One participant argued that it is unfair that cosmetic surgeons perform FGM with immunity while perpetrators of FGM are imprisoned:

They [cosmetic surgeons] wouldn't get 14 years' imprisonment. So I think it's totally unfair. This [FGM] gets 14 years I think they should get 14 years as well. [Focus group one]

Many participants believed that the legal double standard makes FGM stand out as a unique crime. Unlike other crimes it is directed towards an immigrant communities often from former British colonies, raising issues of cultural diversity, race and respect for cultural customs (Winter, 1994: 940). Meanwhile FGCS is legitimized by the law because it is performed by dominant society upon women who are presumed capable of consenting (Braun, 2009; Sullivan, 2001). However, I contend that both practices stem from cultural pressure exerted upon women to change their genitalia to conform to expectations. The legal double standard incites anger and resentment from FGM-performing communities who feel discriminated against by the law:

Yes, I do think there is a double standard in law. I think there should be one law for all whether for women over a certain age or not because there are double standards. We are trying to bring *change* in practicing communities about cutting and removing parts of the female genitalia and I think it should be the same for all. [P13, FGM-PCM and nurse, *Somalia*]

FGM for me is against the law. It should be against the law irrespective of who you are and where you come from. [P11, FGM-PCM, *Unknown*]

The participants argue that the law should apply to all women rather than targeting ethnic minority communities. Instead, state interference intrudes into the lives of poor ethnic minority women, which increases the risk of their children being moved into state care and the arrest and prosecution of women who are themselves victims of FGM (Sokoloff & Dupont, 2005). Perceived discrimination through the law exacerbates the structural barriers to women accessing the criminal justice system. Targeting immigrant communities with anti-FGM legislation could inhibit change in eliminating FGM rather than encouraging it.

One way of eliminating the legal double standard is to criminalise FGCS. A minority of women participants linked FGM and FGCS as a means of arguing for the prohibition of both practices. Women unintentionally adopted a feminist position, as they argued that the practices stem from cultural pressures that seek to regulate women's sexuality (Duits & Van Zoonen, 2006; Jeffreys, 2005). The argument is that women are undergoing surgery to conform to the ideal genitalia defined by cultural expectations in the West and in other cultures. Women in the first focus group argued:

- I think the problem really lies with, why does a 13-year-old or adult really think that her private part is not beautiful. It's this whole sexualized society that they've been exposed to.
- In a way it's down to socialisation. She would probably see it from other girls and think that hers is not pretty enough. In the same way in Somalia they will probably see other girls with it done and think why is not mine looking that way. So it's the same reason but with different cultures. I think in a way they are both wrong and they should both be illegal if they are under 18. [FG1]

Interviewer: Have you come across FGCS?

Participant: It's like the same thing [as FGM]... you are not doing it for you, you are doing it for men. It's exactly the same. [Although] They made the name [FGCS] sound nicer than infibulation. [P12, FGM-PCM and teacher, *Somalia*]

The arguments advocated by a minority of participants evoke feminist scholars who have drawn links between FGM and FGCS for different political ends. Feminists argue that the issue of FGM is not *just* about African communities but about the abuse of women's bodies across the world (Davis, 2004; Greer, 1999; Weil Davis, 2002). Women experience cultural pressure to conform to such practices for fear of rejection and social stigma both in the West and in FGM-performing communities (Dustin, 2010: 13). If women are socialised or pressurised to undergo FGM or FGCS, it raises questions about the validity of women's consent to the embodied practices. The political purpose of comparing both practices is to advocate for reconceptualising FGCS as a harmful cultural practice in the West that should be criminalised. Both FGM and FGCS would then be outlawed.

However, academic Pedwell (2011) cautioned feminists in mobilising a narrative of gendered similarity across cultures, due to fears of essentialising women rather than recognising differences on the basis of race, class, age and culture. The quotations above show that women from FGM-performing communities themselves mobilise a narrative of gendered similarity. Pedwell (2011) ignores the fact that women from across the globe, not solely western feminists, draw comparisons between divergent cultural practices for different political ends. Furthermore, Pedwell (2011) fails to take a nuanced approach when conceptualising culture, as she overlooks the comparable cultural drivers that underpin FGM and FGCS. I argue in this thesis that both practices are products of cultural pressures emerging from deeper discourses around beliefs about beauty and women's roles in society.

It is evident that the legal double standard is a barrier to the law deterring and preventing FGM. Criminalising FGCS could remove this barrier. FGM and FGCS would then be treated the same by the law. After exploring women's attitudes and beliefs towards the barriers of anti-FGM laws, the second part of this chapter examines what stakeholders believe are the barriers to anti-FGM laws deterring and preventing FGM.

Stakeholders' Attitudes to the Barriers Preventing Anti-Female Genital Mutilation Laws Working in Practice

The second part of the chapter examines what stakeholders believe are barriers to anti-FGM laws operating effectively. The findings compare and contrast with women's attitudes and beliefs towards the barriers in the first part of the chapter. It is important to ascertain whether stakeholders understand the key barriers to the laws as described by women in the first part of the chapter. Moreover, I explore whether stakeholders apply an intersectional lens of gender, race, culture, class, nationality and religion to reflect upon the impact of the barriers on women's lives. The key barriers examined are racial tensions between law enforcement agents and FGM-performing communities, the unique familial dynamics of FGM, which make prosecuting cases challenging, stakeholders' lack of knowledge about FGM, and the double legal standard in prohibiting FGM while permitting FGCS.

Racist Conceptualisations of Female Genital Mutilation in Political Discourse

Interview participants with experience of the legislative process outlined their attitudes of the barriers to implementing anti-FGM legislation. It was apparent during interviews that there is a divide in knowledge and understanding about FGM between the political elite responsible for designing legislation and FGM-performing communities, the subjects of the law. The language used by the political elite during debates shows their "devaluation of black women and the marginalisation of their sexual victimisations" (Crenshaw, 1991: 1268). The political elites' ignorance and disinterest in FGM could be viewed as a barrier to effectively designing and implementing anti-FGM laws. A male Member of the House of Lords described his reluctance and embarrassment in debating FGM in Parliament in the early 1980s:

You would understand that this isn't my favourite subject. It's not something that I'd even heard of... I was only too glad to get rid of the whole subject quite honestly. When you had to deal with it the whole time and it was on the television and one's

friends revelled in this mockery that went on. But there we are, we are grown up people [laughs]. [P21, Member of the House of Lords, M]

The quotation highlights that the political elite did not reflect upon women's experience of FGM, which would have been impacted by their gender, race, culture, class and religious identity. Feminist scholar Bunch (1990) argued that white men designed and enforced human rights upon people including women who were denied the right to construct the law. It appears that FGM was not prioritised as a practice to eliminate perhaps because it did not impact upon the lives of white male politicians. Instead the participant said he was only "too glad to get rid of the whole subject." A Member of the the House of Lords explained that politicians were disinterested in FGM because it was not a part of their culture or identity:

There was a generation of the Lords who viewed it is a barbaric practice but didn't particularly care about it because it wasn't part of their culture... there are still some people who don't want to know about those things because they are unpleasant and distasteful to them, but this is a matter of personal temperament, isn't it. [P25, Member of the House of Lords, F]

The popular FGM discourse plays a role in polarising 'us' – representing the freedom of the West – and 'the other,' who are the victims of barbaric practices (Dustin, 2010: 11). The ethnocentric tone of politicians is a form of cultural imperialism (Brennan, 1988: 370). The polemic nature of anti-FGM discourse can lead to racist assumptions of cultural and religious groups (Gunning, 1991: 213). Politicians' ignorance and disinterest in FGM could be a barrier to effectively designing and implementing anti-FGM law. Furthermore, politicians' marginalisation of FGM-performing communities from the consultation process could be a further barrier to the law working effectively. A Member of the House of Lords explained the lack of consultation process with FGM-performing communities:

We never met any of the people who felt it was something that should be done. We were told it was custom and it was a habit and they were doing it because of protecting them from intercourse, having too many boyfriends. But we never met any of the people. We met the people who were campaigning against it. [P26, Member of the House of Lords, F]

Politicians only consulted with selective anti-FGM campaigners who reaffirmed politicians' preconceived views about FGM and thus supported the criminalisation. Politicians made no attempt to consult with defenders of the practice (Rogers, 2013: 23). The bias of the

consultation process is a form of discrimination against marginalised communities. This could have solidified community objections to anti-FGM legislation. A Member of the House of Lords who was involved in criminalising the practice in the 1980s explained that she encountered a backlash from women who supported the practice:

I remember the first day I was there [in Parliament] and I came out of the Chamber and there were black ladies there and they took one look at me and they shook their fists at me. And they said, “don’t think you’re going to stop it dear, if you try and stop it we will do it on the kitchen table.” Just like that. Two great big black ladies who had been listening in the gallery and were associated with their tribes. They are not a bit interested in the law in this country. They are just interested in getting these poor girls under the knife, really. So that rather shook me. [P25, Member of the House of Lords, F]

The political elite projected narratives of barbarism upon immigrant communities when they had no understanding or knowledge of FGM (Dustin, 2010: 19). The participant described visceral images of savages shaking their fists and threatening to cut girls on the kitchen table. The story told by the participant relates to discussions by scholar Rogers (2013), who argues that a singular violent image of FGM accompanies the introduction of anti-FGM law (23). Such images involve the suppression of other stories which may contradict or compete with the overarching image of a child being held down and cut (Rogers, 2013: 23). Werbner (2013) warned against applying visceral images in the public consciousness for fear of arousing racist stereotypes of Muslims as child abusers. Laws and policies designed to prevent FGM have provoked resentment and hostility rather than encouraging collaboration in working towards the elimination of FGM (Dustin & Phillips, 2008: 146). This could serve as a barrier to the law working effectively and deterring and preventing FGM.

Racism as a Barrier to the Implementation of Anti-Female Genital Mutilation Laws

As described in part one of this chapter, the relationship between law enforcement agents and FGM-performing communities is fraught. Women described their experiences of structural racism and sexism through the law, which deters them from accessing the criminal justice system for cases of FGM. During the interviews, I probed stakeholders as to whether they believe racism and cultural ignorance is a barrier to the enforcement of anti-FGM law.

In chapter five women described examples of resistance to anti-FGM laws by continuing the practice underground. A Member of the House of Lords appeared to understand the impact of criminalisation upon the practice, as she stated that anti-FGM laws could alienate communities and result in further segregation between immigrant communities and mainstream society:

If they [law enforcement officers] are against families it will simply make families turn in and become more cut off from wider society. I think it's potentially damaging. We want integration in this country... Not if these communities are alienated anyway and pretty cut off from society. They will simply feel more alienated and cut off and it could really be quite damaging. [P23, Member of the House of Lords, F]

Rather than deterring and eliminating FGM, the Member of the House of Lords cautions that communities could feel stigmatised by the law and popular discourse and thus retreat within their community. The quotation reflects concerns that criminalisation campaigns continue the abuse perpetrated by Western powers that sought to colonise the 'other' during efforts by the British Empire to colonise parts of Africa (Winter, 1994: 940). African-American scholar Gunning (1991) cautions against invoking the criminal law to eliminate FGM, which she warns could have the unintended consequence of reinforcing the practice. Instead she argues for a grass-roots approach led by the community of education and health initiatives.

Stakeholders cautioned that criminalisation could lead to communities resisting the law and performing FGM underground. This shows stakeholders' awareness of the barriers to the law operating effectively. According to a barrister specialising in criminal law, anti-FGM laws could have had an adverse effect, rather than encouraging communities to abandon FGM, communities might resist the law and representations of cultural customs and continue to perform FGM:

The law can harden attitudes. If the UK law says a particular thing, one could imagine a community, which practices FGM to have allegiance to FGM strengthened to what it perceived as a dismissive or unsympathetic community. [P48, Lawyer, F]

Parallels can be drawn between present day resistance efforts and resistance towards colonial attempts to ban FGM in parts of Africa. During the British Empire, FGM became a symbol of anti-colonial solidarity and resistance in parts of Africa including Sudan in 1949, which imposed a ban on FGM (Brennan, 1988: 379). As a result, colonial efforts to ban FGM were abandoned in the 1940s and 1950s. Erica Burman (2005) and Marranci (2004) cautioned

against criminalising cultural practices because such customs acquire power through becoming practices of resistance to imperialism. Comparisons can be drawn with laws prohibiting the wearing of the Islamic veil: rather than unveiling women, Muslim women have resisted the law by adopting the veil as a public show of defiance of national laws (Scott, 2009).

A local authority employee who works closely with FGM-performing communities explained that communities are concerned about the punitive nature of policing of FGM:

I mean I've heard some communities who say they want to go to their country of origin, in this case Somalia and they are nervous about going to the airport with two daughters because they think social services will take them off them because of the airport checks that were being done last year. [P20, Local Authority Employee, F]

The stakeholder explained the punitive forms of policing women encounter from law enforcement agents to deter and prosecute cases of FGM. Policing can be regarded as a structural form of oppression enforced upon immigrant communities, as concerns about FGM legitimise the surveillance of ethnic minorities. Women may fear calling the police as it could subject them and their families to racist treatment by the criminal justice system, as well as confirming racist stereotypes of black families as violent child abusers (Sokoloff & Dupont, 2005). The result is that communities distance themselves from law enforcement agents rather than engaging. An NGO worker described an evocative case in which the police had wrongly accused families of intending to perform FGM on their daughters:

Local police depends, it's kind of a lottery, they either overreact or not react at all... There's still no trust between the police and community organisations because they get it wrong quite a lot. We've had cases where people are just travelling to a country where FGM is performed and the father went to get the jabs for the girls and the doctor was alarmed because three girls were travelling to Somalia. The doctor reported it to social services, that's fair enough. The police went in without an interpreter, mum couldn't speak English, dad was away. Procedure to take everyone's passports that was even before the current change in legislation. They took everyone's passports, the woman was in complete shock because there was no interpreter and no one was there to assess them. They [the family] were completely against FGM, I mean the woman had the infibulation and she was actually accessing one of our projects and she was very vocally against FGM. And they missed the flight

and they had been saving the flight for years to visit the grandparents, so yeah there's instances like that all the time. [P59, NGO Worker, F]

The quotation indicates that the police do not have a mainstreamed approach to dealing with cases of FGM, instead the approach of the police depends on the areas in which they are based. The penal approach described by one family could have been shared with other community members, which may result in women's reluctance to cooperate with the police due to fears of arrest or prosecution. Dustin and Phillips (2008) argued that government policies designed to curb FGM in immigrant communities could have provoked resentment and hostility amongst FGM-performing communities. A CPS worker explained the difficulties of the police working closely with immigrant communities:

Interviewer: Would it help if the police worked closely with communities?

Participant: Of course yes. But it's difficult because a lot of the affected communities are asylum seekers, or they have tenuous immigration status or they are hidden in some other way from authorities and they tend to be communities that are marginalised and the police don't have particularly good established links with those communities as they do with the diaspora communities. [P69, Crown Prosecution Service Employee, M]

There are practical difficulties of forging a relationship with immigrant communities when they are marginalised and disenfranchised due to their tenuous immigration status. Furthermore, women's experiences of discrimination through the law may deter them from coming forward and seeking support from the criminal justice system. As it is challenging for the police to establish direct links with the communities, they have tried to forge relationships with self-appointed male community leaders. An NGO worker criticises the police for focusing resources on building relationships with patriarchal community leaders that do not support gender equality:

We think the police don't work closely enough with the right people in communities, in particular women. We think the police all too quickly engage with self-appointed leaders or perhaps the Imam and so on and neglect to really engage with women in the community, mothers and so on. We need to get to that silent majority. [P63, NGO Worker, F]

There has been much discussion in the literature about service providers working with male self-appointed community leaders to build relationships and prevent any offensive to the

community (Bradley, 2011; Erica Burman et al., 2004: 347). However, academics have criticised service providers including the police for privileging race over gender as they work with male community leaders who are often responsible for reinforcing patriarchal power relations within minority communities (Erica Burman et al., 2004: 347). The result is that violence against women and girls is rendered invisible and women continue to lack protection within their community. Women are left unprotected by the police because of institutional racism within the police force and other service providers who privilege race relations over gender equality (Maynard & Winn, 1997: 181). This could serve as a further barrier to anti-FGM laws being effectively enforced.

A key barrier to enforcing anti-FGM laws was stakeholders' "race anxiety." According to a teacher interviewed, other teachers have been unwilling to take action in cases of FGM because they feared they would be branded racist:

At this primary school project, I was assessing the level of the girl's English and there was this year four girl. To cut a long story short, she disclosed that she had been cut the previous summer. It was the first term of the year, so I can't remember if that was 2007, or maybe even 2006, but the school didn't want to know ... It was just impossible to get any answers anywhere. What I saw was a British girl in a different group of child protection rules. It was so completely racist and unacceptable and unfair and cruel and I couldn't do anything about it because no one was listening. [P78, Teacher, F]

Erica Burman (2003) argues that stakeholders within public institutions, such as teachers, police, social workers and medical stakeholders are particularly conscious of being labelled racist if they focus on culturally specific practices (298). Ethnic minority girls are left unprotected by mainstream society because of stakeholders' race anxiety (Maynard & Winn, 1997: 181). Erica Burman (2003) argues that through efforts to avoid being racist the opposite occurs, as ethnic minority girls are invisible and marginalised by white workers.

Furthermore, the failure to challenge assumptions about culture and traditions feed racist stereotypes that other communities condone violence and are oppressive to women (Erica Burman, 2003: 301). Dustin (2010) argues that an obstacle to stakeholders supporting women is that violence against ethnic minority women is viewed as intrinsic to their culture (9). In contrast, violence performed against Western women is seen as an aberration of the individual man (Dustin, 2010: 9). Dustin (2010) contends that violence defined as perpetrated by

cultural traditions should be reframed as gender-based violence rather than linked to culture, race or religion (9). This could encourage stakeholders to take action in cases of FGM.

A social worker explained that stakeholders are paralysed into inaction in cases of FGM because of race anxiety:

Sometimes stakeholders don't want to talk about abuse that's related to certain cultures or race. Some of them don't even want to get involved because they are not sure how to handle the case and they are scared of being called racist. [P75, Social Worker, F]

It is not uncommon for service workers to present as insufficiently equipped to work with ethnic minority women due to sensitivities about culturally inappropriate questions. All of the stakeholders interviewed believed that concerns about being labelled racist impaired stakeholders' child protection duties, which could have resulted in vulnerable children being left unprotected. An NGO worker who was involved in the legislative process stated that politicians and law enforcement agents failed to ensure the law was enforced because there was no interest in protecting ethnic minority girls from immigrant communities:

There was an unwillingness to take the issue seriously. For me the why, why goes, because of who it is happening to, these are mainly black refugees, asylum seekers and most of the cases that are found are people in that category and it's not in the interests of the British public to actually do something. [P34, NGO Worker, F]

Black girls from immigrant communities at risk of FGM are often poor and disenfranchised and lacking the resources to seek support. The failure of stakeholders to protect young black girls from FGM is an example of racial discrimination. Academics have also argued that leaving vulnerable girls without protection is racist, as white stakeholders prioritise their own concerns over the needs of vulnerable girls (Maynard & Winn, 1997: 181).

Another barrier to stakeholders enforcing the law is stakeholders' personal attitudes towards FGM, which conflict with their professional duties to report cases. This highlights the blurred lines between women and stakeholders' attitudes. While the predominant theme throughout the study is that the two groups have divergent attitudes, where the groups overlap and women are also stakeholders, there can be overlap between the two groups. This is a rare occurrence; the majority of women are not stakeholders thus I do not believe this undermines

the claim of largely polarised attitudes between the two groups. A social worker describes the conflict social workers confront on a personal and professional level:

On a stakeholder level they [social workers] see it as abuse but on a personal level they like it. It's very weird. Because some stakeholders like to detach their profession from their personal beliefs and this is where the danger is. Because if for example you have a South African or Zimbabwean social worker who has gone through this [labia] elongation and then in her profession she is asked to raise awareness of FGM being abuse, it contradicts. They are happy to do it as a stakeholder and when they finish work they take that hat off. I have seen a lot of social workers in different arenas like that and it's worrying. [P75, Social Worker, F]

The quotation describes the conflict between personal attitudes that support FGM and a stakeholder's duty to intervene in cases of FGM. Stakeholder's lack of commitment to eradicating FGM could mean that girls who are at risk of the practice are not protected from child abuse. The government introduced a criminal offence in the Serious Crime Act 2015 where stakeholders would be liable if they failed to report cases of FGM. This clarifies stakeholders' professional duty to report cases. However, there are concerns that stakeholders are not trained about FGM, thus they continue to have a lack of knowledge or understanding of the practice or how to deal with FGM, as described by one NGO worker:

There hadn't been much effort in enforcing the law. Enforcing the law requires training, people being informed. But they hadn't been. It also requires making sure people have clarity in terms of the protocol and guidelines, in terms of how you follow. [P34, NGO Worker, F]

The lack of training for stakeholders and knowledge about FGM is a barrier to the implementation of the law. The failure to enforce the law sends out a message that the government is inadvertently legitimising the oppression of ethnic minority women (Lewis, 1995: 9), which could be construed as racist as ethnic minority girls and women are left unprotected (Maynard & Winn, 1997: 181).

Despite the recent introduction of this offence, there has still not been one conviction for FGM related offences. Having discussed the racial barriers to the laws working effectively, I will now move onto discussing the unique nature of FGM as a criminal offence due to the complex familial and community dynamics.

Female Genital Mutilation: A Unique Familial and Community Offence

Unlike other criminal offences, prosecuting cases of FGM raises unique problems, which could be regarded as barriers to the law working effectively. One of the most significant challenges according to Dustin and Phillips (2008) is that the offender is usually related to the women or girls and they are unlikely to consent to the prosecution of offenders. There was consensus amongst stakeholders that a key barrier to obtaining a conviction for FGM was the familial and community nature of the offence. A Crown Prosecution Service worker described the challenges of encouraging victims to give evidence against relatives:

We've had victims come and say they won't give evidence against their family or community. All we can do is risk assess the best I can... Victims are scared. They don't want their parents to go to prison... Obviously the more serious allegation the more I would consider a witness summons and actually taking people in and turning them hostile, but that's the last resort because people are so adamant that they don't want to give evidence in a lot of cases and the difficulty is you have got to be sure you don't completely alienate them from the criminal justice system so they don't report again. [P70, Crown Prosecution Service Worker, F]

Coercing victims to give evidence against their relatives could re-victimise girls and women, which would alienate victims from the criminal justice system. The failed prosecution case of FGM is an example of the complainant's reluctance to support the prosecution of her former doctor and her husband. In this case, the victim gave evidence on behalf of the defence rather than the prosecution, thus the victim supported her husband and the doctor who was standing trial for FGM related offences. A Crown Prosecution Service worker explains the unusual dynamics of the first FGM prosecution:

I think the unusual nature of the first FGM case is that the victim gave evidence for the defence. She didn't give evidence for the prosecution. The victim gave evidence for the defence. She gave evidence for her husband. And that's the other challenge, when we look at victims they are conditioned to believe that FGM is right for you... that's the category I'd put this victim in. That's another challenge for law enforcement and investigators because that individual might not be a party to the investigation, ultimately they may choose not to even give evidence for the prosecution and could give evidence for the defence and that's what makes that quite unique really. [P68, Crown Prosecution Service Worker, F]

As described in the quotation above, girls and women may wish to uphold the practice and therefore refuse to support a prosecution for FGM. In the failed prosecution case, the prosecution cross-examined the victim on the basis that she was complicit in FGM. A lawyer explained how the cross-examination played out in the courtroom:

The crown had to cross-examine the victim of FGM... That was unattractive and not only did she cross-examine but she cross-examined rather aggressively which was quite extraordinary... She was basically suggesting that this woman had been complicit in her own reinfibulation. Not nice. The other thing that, that revealed ... was an undercurrent of racism. Oh you're from Somalia therefore you must be in favour of FGM. Not taking into account individuality, the effect of living in the West. I thought that was unattractive. [P46, Lawyer, M]

In the courtroom, the Crown Prosecution Services drew upon cultural and racial stereotypes of black women being complicit in their own abuse on grounds of cultural necessity to explain the complainant giving evidence on behalf of the defence. Parallels can be drawn with this case study and the trials of FGM in France. Winter (1994) contends that lawyers in FGM trials in France reinforce negative stereotypes of immigrant communities to their advantage, arguing that they are illiterate Africans who do not know any better or that they act according to their cultural traditions that carry the weight of the law in their communities (948, 949). The cultural narratives that play out in the courtroom reinforce racial discrimination towards black women and girls who are described as cultural dupes, while defendants are dehumanised as “savages” or “beasts.” Such narratives are likely to deter women and girls from reporting cases of FGM to the police. Having discussed the unique nature of FGM as a crime, I will now move onto exploring whether a lack of education and community awareness of anti-FGM laws is a barrier to the enforcement of law.

Knowledge or Ignorance of Anti-Female Genital Mutilation Laws

A key theme during the interviews was communities' awareness of anti-FGM laws. Stakeholders were divided about whether communities are aware of the criminal status of FGM. The findings can be compared and contrasted with the findings from the interviews with women who stated there was a lack of education and knowledge about the law of FGM. Member of the House of Lords responsible for designing and introducing the initial

legislation in 1985 believed the criminal status of FGM would educate communities and mainstream society about the practice and the criminal consequences of FGM:

I suppose what it [the law] has done is to generate a lot of publicity and to have alerted the population in general to something, which makes it simply awful for those young girls who suffer this abuse for cultural reasons. [P21, Member of the House of Lords, M]

The law increased public awareness of the practice, however it is unclear whether the publicity about the law permeated immigrant communities. Without raising awareness of anti-FGM laws in FGM-performing communities, many women would be unaware of the introduction of criminal sanctions. A Member of the House of Lords involved in implementing the law in 1985 stated that there were no implementation plans for the legislation. This reflects the failure of law enforcement agents to prioritise FGM.

We really didn't have any plans as far as I can remember of putting the legislation into practice. I have no idea if it was implemented. Nobody wanted to do it of course. [P24, Member of the House of Lords, F]

The stakeholder is frank in stating that there were no implementation plans, which could explain the barriers to the law being implemented. Furthermore, a Member of the House of Lords stated that there is no evidence to show that the law is a deterrent, as it is impossible to measure the efficacy of law:

I think one of the most disappointing things about the law is that we haven't had one prosecution. What we will never know is whether the law has had a deterrent effect. We will just never know or understand that. I don't think there is any way we can. There's part of me that would love to think, yes we haven't got prosecutions because the law was working well. [P22, Member of the House of Lords, F]

There was consensus amongst stakeholders that anti-FGM laws do not appear to have been effective in deterring FGM because the law has not been enforced. The argument is that one successful prosecution of FGM is required to heighten awareness and send a symbolic message to perpetrators that the practice will not be tolerated in England. Without one prosecution for FGM, stakeholders question whether communities are even aware FGM is a criminal offence. A police officer working with FGM-performing communities explained that people are not aware that FGM is a criminal offence:

I think there are all sorts of problems that surround that law and the major one is that I think still in this day and age the isolated nature of ethnic communities that practice FGM means that they may well not be aware of the FGM laws... I don't think enough work has been done to engage communities and let them know how very wrong it is in terms of the law ... I give presentations to community groups and they are still surprised and shocked that it's against the law. [P66, Police Officer, M]

The stakeholder's comments show the top down approach of implementing anti-FGM legislation. The law has yet to filter down to immigrant communities at a grass-roots level, as they live segregated from mainstream society. The challenge is educating communities about the law when there is a lack of resources to run community engagement programmes. A local authority employee explains the need for community programmes educating women about FGM:

At the moment there's a big gap there. Centrally, the government issued all these directives but then it's not giving much thought on how this should be directed to communities, because some community groups aren't even funded, but they do community engagement work and they are not always the best people to do that work because they themselves might have certain views about it, the procedure. [P20, Local Authority Employee, F]

Stakeholders' concerns that communities are not educated about anti-FGM laws reflect findings from interviews with women in the first part of the chapter. Women confirmed that community members are unaware FGM is a criminal offence. It is unlikely that the law can have a deterrent effect when community members are not aware of the illegal status of the practice. African-American academic Gunning (1999) advocated for educational and communities awareness raising rather than punitive criminal strategies, which she believed would be more effective in changing attitudes and beliefs.

During the interviews, medical practitioners described their attempts to educate women about the law. They tried to use the law as an advocacy tool to encourage FGM-performing community members to abandon the practice. Two medical stakeholders explained how they use the law to deter women from performing FGM:

We had a clinic last week. Seven new patients and we had discussions about the law in this country and the law in their country of origin and as is often the case, there are

laws criminalising FGM in their country of origin. Somalia is a classic example, it's [FGM] been criminalised since 1946 but people don't adhere to the law. So the challenge for me is to say, actually in your country you may have a law and no one listens to that law. It's a corrupt approach to that law but in this country the law is here and we will use it. [P39, Consultant Obstetrician and Gynaecologist, F]

I am asking everyone that I see, I am giving them passports, it's called an opposing statement, it comes in 11 languages. It's there to take abroad when they travel to show to their family members and it states what FGM is, the penalty for it and how they can make contact to get help if required. So that's part of the work that I do. It is just part of the UK initiative. What I do is, I read it with them... I will still give her a Somali copy so that she can take that and give it to others, she can give it to family members. [P33, Midwife, F]

Stakeholders encouraged women to use their knowledge of the law as an advocacy tool to negotiate with family members abroad to persuade them to abandon FGM. In the literature on forced marriage, academics argue that the law against forced marriage was a bargaining chip that women used to persuade family members not to force them into marriage (Gaffney-Rhys, 2014; C Proudman, 2012). Women could argue that if they are forced into marriage their families might face criminal sanctions, which might deter families from arranging the marriage. In circumstances where girls and women support the elimination of FGM, a former midwife explained that a girl used the law as a bargaining chip to negotiate with parents to encourage them to abandon the practice:

This young girl last year told me, mum and dad you are not to mutilate us because you will lose your child benefit and she said none of us have been cut. Those parents know their children have an insight into the world that it is now and they have linked it to an economic factor. I mean not only would they lose their child benefit they would lose their children. [P29, London Assembly Member, F]

In this case, the girl used economic resources provided by the state as a bargaining chip to negotiate with her parents to ensure she was not cut. It is noted welfare benefits were given more weight in negotiation than criminal sanctions. This section of the chapter shows the challenges stakeholders confront in educating communities about anti-FGM laws and the difficulties of using the law as an advocacy tool to encourage communities to abandon the practice. The education barrier to the law working effectively could explain why FGM persists even when it is a criminal offence. The final section explores whether the legal

double standard in permitting FGCS while criminalising FGM is a barrier to the law deterring and preventing FGM.

The Legal Double Standard: A Further Barrier to Eliminating Female Genital Mutilation?

As identified in the first part of the chapter, a further potential barrier to eliminating FGM could be the legal double standard of criminalising FGM while tolerating FGCS. Women in the first part of the chapter linked the practices for the purpose of opposing anti-FGM laws and supporting the decriminalisation and medicalisation of FGM in line with FGCS. In contrast, the majority of stakeholders believed the practices are polar opposites (Braun, 2009). Stakeholders did not consider women's attitudes and beliefs towards the legal double standard and whether this might present as a barrier to anti-FGM laws deterring the practice. A lawyer explained that even attempting to suggest FGCS and FGM are similar practices is offensive:

Is there anything wrong with a woman who has the capacity to make a choice and is not under any duress, cultural pressure and goes into Harley Street and says this [FGCS] is what I want, is this wrong? [P46, Lawyer, M]

There was a perception amongst stakeholders that Western women supersede cultural influences and make empowered choices to undergo FGCS while non-Western women are seen as influenced by culture and unable to make autonomous decisions (Braun, 2009; Gillespie, 1997; Sullivan, 2001). The lawyer did not believe that defining the practices as different in law constitutes a barrier to the law being implemented.

A cosmetic surgeon also distinguished between the practices on grounds of culture and religion. The surgeon argued that while cultural and religious motivations determine FGM-performing communities' decision to undergo FGM, they are irrelevant when deciding to undergo FGCS.

Surgery on the labia I think is a distinctly different procedure from FGM. In the sense that is clearly on cultural and religious grounds... [P73, Cosmetic Surgeon, M]

The cosmetic surgeon believed that cultural and religious reasons for undergoing genital surgery only exist within ethnic minority communities. The participant did not acknowledge that women undergo FGCS because of cultural norms in Western society. Feminists Kathy

Davis (2004) and Simone Weil Davis (2002) argue that FGM and FGCS are linked to ideas about gendered body norms within different cultural contexts. Cultural norms are the drivers for the persistence of FGM and FGCS. Women conform to ideals of the 'normal' genitalia due to fear of shame and rejection within their respective communities (Dustin, 2010: 13). Failure to acknowledge perceived similarities between the practices shows contrasts with the findings from the interviews with women who compared FGM and FGCS.

A consultant gynaecologist and obstetrician disassociated FGM and FGCS on grounds of divergent motivations:

FGM is more obviously about removing sexual pleasure and access and the other [FGCS] is about enhancing or about improving sexuality and have enhancements, or you remove the clitoral hood so the clitoris sticks out more, in the sense of it is a cultural determination of what is normal for a woman's behaviour. So no I don't think they are the same thing. [P42, Consultant Gynaecologist and Obstetrician, F]

The stakeholder describes FGCS as enhancing and empowering while FGM is described as curtailing a woman's sexuality. The participant's view could be criticised as ethnocentric. The participant does not consider that women in different cultural contexts *choose* to express their sexuality in a variety of ways (Korieh, 2005). Furthermore, the participant does not consider that both practice stem from cultural beliefs about women's bodies. African women who undergo FGM also use the language of liberation and empowerment to justify *choosing* FGM, as identified in part one of this chapter. Stakeholders struggle to identify how this legal double standard impacts upon women's attitudes towards anti-FGM laws.

A small number of stakeholders argued that there is a double standard in law in prohibiting FGM while permitting FGCS. This reflected the attitudes of women in part one of this chapter. The findings show the fluidity and overlap of some findings between the two groups, however it must be emphasised that such blurred lines are rare. A lawyer explained that both practices stem from patriarchal and oppressive norms that dictate how a woman's genitalia should look and function:

When women are starting to mutilate themselves, whether FGM or female genital surgery, that's a very different animal because if it is a legacy of male cultural dominance and oppression... It seems to me that the genesis of that cultural practice is also steeped in patriarchy, conforming to some idealized, stereotyped view of an acceptable sexually enticing woman, which derived from male dominance it seems to

me... I have got no problem whatsoever in a radical critique in saying what it is doing is reinforcing not only the social control of women but also demeaning and objectifying women more generally, for me those considerations prevail over, I want to opt into it. [P47, Lawyer, M]

The participant's quotation reinforced the work of Western feminist who compared FGM and FGCS (Duits & Van Zoonen, 2006; Jeffreys, 2005; Weil Davis, 2002). Scholars argue that girls and women who undergo genital surgery are denied agency and autonomy by cultures that coerce them to conform to patriarchal body norms. Whether performed in the West or in minority communities, genital surgeries reflect societal and cultural norms about how a woman and girl's genitalia should look and function. Furthermore, an NGO worker who works closely with women at a grass-roots level believed the cultural pressures to undergo FGM and FGCS are comparable:

The pressure for that white girl to undergo any form of labia reduction is the same pressure as girls undergoing FGM. But for me the issue should be if you are able to empower women this is why we need to talk about FGM, at the continuum of women inequality, because why should a woman do this to her body. And because there is pressure by society and social norms either through the media, or through the community or through traditional leaders it is a continuum of dictation. [P34, NGO Worker, F]

The participant mentions a 'continuum of women's inequality', which relates to the concept of 'continuum of violence against women' founded by feminist academic, Liz Kelly (2013) to highlight that various forms of abuse and violence are connected. The pressures women experience to undergo FGM or FGCS might also exist on a continuum of violence against women. A midwife outlined concerns that the legal double standard reinforces racial stereotypes, as white women are depicted as empowered by undergoing FGCS, while black women subject to FGM are defined as victims:

On the one hand we are campaigning to stop FGM and it's horrid and FGM is child abuse and awful and these women are treated like nothing and in our own culture when white women do it then that's fine, it's normal. I think there is a big sort of racist element in that. White women are allowed that autonomy and this labia plasty culture is white and it's part of the body beautiful, slim, blonde hair, big breasts, I don't think of it in terms of ordinary women. I associate it with women who would try and perfect other areas of their bodies and lifestyles. [P36, Midwife, F]

The racial stereotypes attached to the practice of FGM and FGCS could serve as a barrier to women seeking access to the criminal justice system. Women might fear contacting the police in cases of FGM, as the police could subject them and their families to racist treatment (Sokoloff & Dupont, 2005). Women interviewed in part one described the hostility and anger they feel towards the legal double standard, which could be responsible for inhibiting changes in attitudes and beliefs towards FGM. Only a minority of stakeholders showed an awareness of how the legal double standard could serve as a barrier to anti-FGM laws deterring and preventing FGM.

An NGO consultant explained that the legal double standard makes it challenging to use the law as an advocacy tool to encourage communities to abandon the practice:

Community groups who were doing community awareness it was quite hard for them because people would say well what if I had a designer vagina, what if I trimmed my labia does that count as FGM, why is that FGM, why is this not FGM. So it was raised as an issue and that's when there was lots of voices coming back from the community groups themselves were often quite nervous about talking about FGM. They really sort of progressed in terms of their arguments. [P58, NGO Consultant, F]

Part one of this chapter shows that women are aware of the legal double standard. The findings from interviews with stakeholders who work closely with communities shows the challenges they confront when encouraging women to abandon FGM when FGCS is permitted. The legal double standard appears to have legitimised women's resistance towards anti-FGM laws and could have resulted in women reinforcing the practice. Findings outlined in part one of this chapter showed that women had undergone FGM under the guise of FGCS. Stakeholders working directly with FGM-performing communities highlighted their concerns that communities are circumventing the law by continuing genital surgery through FGCS:

I think we fear that it [FGCS] may become more and more a kind of a presence in these communities as a way of avoiding the illegality of FGM. And then their parents may be, those who know well enough will take a young child, a 16-year-old through cosmetic surgery they can do it especially because the NHS according to some research, 140 cases of cosmetic surgery has been funded by the NHS. [P11, FGM-PCM and NGO Worker, *Unknown*, F]

This shows stakeholders are aware that FGM is being performed under the guise of FGCS. The participant who described FGM being performed under the guise of FGM has two lenses one of a community member and another as an NGO worker. Her nuanced perspective provides rich information about how the practice has evolved within communities. Two Crown Prosecution Service workers confirmed that they are aware that there is a risk FGM is performed under the guise of FGCS:

I can see the risk if people were allowed to describe what would be seen as FGM in other circumstances as a labiaplasty instead that may offer a way for them to continue to carry out the practice unless there was an equality of the treatment of the two [in law]. [P69, Crown Prosecution Worker, M]

The Crown Prosecution Service worker explains that unless the law treats both practices equally there is always a possibility that community members may try to subvert the law by undergoing FGCS. A cosmetic surgeon described a situation where a woman from an FGM-performing community was seeking FGM to be performed for cosmetic purposes:

I have only ever seen one patient who had undergone FGM in Africa and I decided not to operate on her or do anything surgical on her, but I referred her to a clinical psychologist. She wanted to be closed even further, further FGM. I said I can not do that, I'm unwilling to do that... She wanted it done because her husband wanted it. [P72, Cosmetic Surgeon, M]

This case shows an overlap between FGM and cosmetic surgery. It also highlights that FGM-performing communities are aware of how to continue the practice in legitimate contexts without fear of prosecution. An NGO worker said that she worked with an African woman who attempted to have FGM under the guise of FGCS:

I know of women who have tried to do that [FGCS] but couldn't so there's some sort of discrimination going on in a way. I think she was Sudanese. She wanted to go to the clinic to make her genitals look more like they used to because that was what she was accustomed to... She wanted to make her genitals look smaller, make the opening look smaller. She had been opened up to give birth and she felt she wasn't normal anymore because that wasn't what she was accustomed to. She wanted to go to have cosmetic surgery on what was being offered, but they turned her down effectively because she was from an affected community, there is no other reason

because if she was a white woman she would have had the procedure. It's a weird one. [P59, NGO Worker, F]

According to the participant, there is a double standard in law and practice, as women from FGM-performing communities are denied FGCS while surgery is permitted for Western women. This highlights the racial discrimination black women experience on the basis of preconceived racial stereotypes of culture overriding their capacity to consent to surgery. The double legal standard could be regarded as perpetuating racial discrimination. Thus the laws represent a barrier to anti-FGM laws deterring and preventing FGM.

Conclusion

This chapter examined women's and stakeholders' attitudes towards the barriers of anti-FGM laws effectively deterring and preventing FGM. The discussion relates to the previous chapter's focus on the changes in the dynamics of FGM as a result of anti-FGM laws. The changes to the practice could also be conceptualised as barriers to enforcing the law. Several key barriers were identified. The first barrier to the law operating effectively is lack of education about anti-FGM laws. Women explained that communities were not aware of anti-FGM laws. The majority of stakeholders identified that communities have not been educated about the criminal status of the practice. Stakeholders also noted that they confront challenges when assisting with cases of FGM because they have not been trained in FGM. However, a minority of stakeholders believed that the symbolic force of criminal legislation is enough to send a strong message to communities that the practice will not be tolerated. Such attitudes show stakeholders' ignorance of the marginalisation of immigrant communities from mainstream society.

A further barrier explored in interviews was racial discrimination. Women linked anti-FGM laws to broader structures of oppression within the criminal justice system. Women feared involving the police in FGM cases because of the racial discrimination and stereotypes they experience from stakeholders. Many women responded to anti-FGM laws with anger and frustration arguing that they would continue to practice FGM underground. The majority of stakeholders lacked knowledge and understanding of the racial discrimination women experience through the law. Stakeholders' lack of awareness of women's experiences of FGM and the law contributed to "race anxiety," as they feared intervening in cases because they could be branded racist. Racial tensions and racism is a barrier to the law operating effectively in cases of FGM.

The final barrier to effectively deterring and preventing FGM is the legal double standard prohibiting FGM while permitting FGCS. The legal double standard undermines attempts to use the law as an advocacy tool to change attitudes and behaviours towards FGM. The legal double standard incited anger by women who argued that FGM should also be permitted. In contrast, stakeholders argued that the law is justified in permitting FGCS because it is an entirely different practice to FGM. This shows stakeholders' lack of understanding of how culture within different contexts, the West and in Africa, creates pressure upon women to undergo genital surgeries. Culture is nuanced and exists in Western societies as well as other societies. Stakeholders' lack of understanding about similarities between FGM and FGCS impacts upon their insight into how communities perceive the legal double standard. Stakeholders are unaware that the legal double standard incites anger amongst communities towards anti-FGM laws. There is a practical consequence of the legal double standard. The law provides women with opportunities to perform FGM under the guise of FGCS. A means of preventing the current lacuna in law is to criminalise FGM and FGCS thereby ensuring equal treatment of the practices. Criminalising both practices also sends out a symbolic message that cultural pressure to change women's bodies through surgery is prohibited. This chapter has highlighted some of the barriers to the laws deterring and preventing FGM. The next chapter concludes the thesis and offers avenues for further research and analysis.

Chapter Seven:

Discussion and Conclusion

“I raise my voice and call on others to join me in empowering communities, which themselves are eager for change. We can end FGM within a generation, bringing us closer to a world where the human rights of every woman, child and adolescent are fully respected, their health is protected and they can contribute more to our common future.”

Former United Nations Secretary-General Ban Ki-Moon¹²⁷

The aim of the study is to answer the overarching research question of why FGM persists when it is criminalised in England. This thesis highlights the empirical accounts of women and stakeholders towards the persistence of FGM and the barriers to anti-FGM laws functioning effectively in England. The data provides a significant contribution to the limited literature on FGM in England. This thesis provides an insight into the motivations driving the practice and the challenges to implementing anti-FGM laws. The study frames the discussion in a context of law, policy and politics. My understanding is that this is the first qualitative study exploring women and stakeholders’ attitudes and beliefs towards FGM and anti-FGM laws in England.

To understand why FGM persists in a context of criminalisation, it is important to analyse FGM from the perspective of women and stakeholders. This thesis provides an empirical study of in-depth interviews with 13 women and 64 stakeholders in different sectors and two focus groups with 11 women in each group. Interviews with women showed common themes in their experiences of FGM and attitudes towards anti-FGM laws. Interviews with stakeholders shed light on their attempts to implement anti-FGM laws and the barriers they encounter. The empirical data drew on frameworks of human rights, cultural relativism, feminist theory and critical race theory. The study applied an intersectional lens throughout (Crenshaw, 1991). Indeed, it was important to analyse women’s experiences of FGM within a society in which they confront multiple systems of oppression of gender, race, class, culture, nationality and religion.

¹²⁷ Ban Ki-moon (6 February 2016).

It is clear from the interviews that the way women understand FGM is different to stakeholders' understandings. While women provided multifaceted understandings of FGM, stakeholders held reductive attitudes towards FGM. A better understanding of communities' experience of FGM would help stakeholders combat the practice as well as garnering support from communities themselves. At present, FGM is impenetrable by the British state and stakeholders. One of the reasons communities are indignant about continuing the practice is that FGM is representative of other concerns relating to migrant culture, group rights, race and the defence of their traditions. Communities perceive the British state's interest in FGM as aimed at enforcing British values and standards. A dialogue between women and stakeholders is essential to create change to the practice.

This thesis also attempts to make a theoretical contribution, as I explored the polarised theoretical debates about FGM from a cultural relativist, human rights, feminist and critical race perspective. The purpose was to examine competing theoretical narratives in the literature and apply the theories to the analysis of the empirical data and then form a conclusion on the basis of the evidence available. In the conclusion of this study, I argue that studies of FGM must apply an intersectional analysis to understand the competing oppressions women experience and how this impact upon their attitudes and beliefs towards FGM. As highlighted in the introduction, I am an anti-FGM advocate and therefore support the abandonment of FGM. To work towards this end goal, I also argue that the relevant theoretical frameworks to apply are feminist, human rights and critical race theory. Applying a cultural relativist framework to analyse FGM has significant limitations, not least that it does not necessarily support the abandonment of FGM. However, I also recognise that it can provide a useful tool to critically analyse the practice. The concluding chapter reviews the key findings of the study and contributions to the literature and outlines policy recommendations and suggestions for further research.

The Limitations of Cultural Relativism in Explaining the Persistence of Female Genital Mutilation

Throughout this study cultural relativism has been a running theme. Scholars and interview participants argue that FGM is a legitimate practice within non-Western cultures, as FGM is integral to the identity of communities (Ahmadu, 2000). However, as the former United Nations Special Rapporteur on Violence against Women Coomaraswamy (2002b) argued, women have a lack of influence in defining culture and traditions in male dominated

communities. Findings from the interviews showed the problems associated with situating FGM within a cultural framework only. It reinforces a reductive view of FGM as a cultural practice. The consequence of situating FGM within a cultural relativist framework is that stakeholders, the public and the media condemn the practice as a barbaric cultural custom (Rogers, 2013). Adopting hyperbole language of cruelty and barbarism has the unintended effect of communities withdrawing from working with anti-FGM initiatives and performing the practice underground.

FGM was criminalised in 1985 and yet there has not been one successful prosecution for the practice. For decades FGM has avoided public and political scrutiny because it was defined as a “cultural practice” that deserves tolerance and respect (Coomaraswamy, 2002b: 3). During the interviews, stakeholders described fears of intervening in cases of FGM and being labelled racist. Academic Erica Burman (2003) referred to stakeholders’ fears as “race anxiety.” Stakeholders’ failure to intervene results in cultural issues being afforded greater priority than gender concerns (Erica Burman, 2003: 538). Consequently, anti-FGM laws were not enforced out of respect for cultural differences while girls and women were left without protection and at risk of FGM (Dustin & Phillips, 2008: 408). The former United Nations Special Rapporteur on Violence against Women Ertürk (2009) argued that “culture-based identity politics” has posed “one of the most serious challenges to women’s human rights” (39).

Recognising the tensions that emerge from framing FGM as a cultural practice, Dustin (2010) and Erica Burman (2005) advocated for reframing cultural practices within immigrant communities, such as FGM and forced marriage, as “violence against women and girls.” Redefining FGM as violence against women and girls rather than a cultural practice would prevent the stigmatisation of immigrant communities as violent abusers of girls and women. While it is important to understand that FGM is a practice emanating from culture and traditions, I argue that FGM should be placed within diverse frameworks of human rights, feminism and critical race theory. These frameworks provide an intersectional approach to understanding FGM from the perspective of race, gender, culture, class, nationality and religion. While there are clear limitations to cultural relativism, this thesis has shown that the theory applied within anthropology today does have a valued role in providing critical readings of cultural practices and the dynamics that maintain them. A critical cultural analysis of FGM is imperative to understand the social drivers of the practice, however such an analysis ought not to be used to maintain the practice but rather to eliminate it.

The Need for an Intersectional Framework Encompassing Human Rights, Feminism and Critical Race Theory

Women's rights are human rights. Historically, international human rights did not *always* account for women's lives and the oppression women experienced (Brems, 1997; Bunch, 1990; Coomaraswamy, 2002b; Kim, 1993). The United Nations and other international human rights organisations now recognise that eliminating gender-based violence practices is fundamental to human rights (Lewis, 2003; United Nations Human Rights Office of the High Commissioner, 2014). Achieving this requires adopting a feminist and human rights framework to understand the ways women experience violence and the strategies that are needed to promote equality (Ertürk, 2009; United Nations Human Rights Office of the High Commissioner, 2014).

I argue that FGM should continue to be recognised as a violation of women and girls' international human rights (Coomaraswamy, 2002b). The literature review¹²⁸ and findings from the interviews with women and stakeholders show that FGM is motivated by the regulation and control of a woman's body and sexuality, which undermines essential values of freedom, equality and dignity¹²⁹ (Coomaraswamy, 2002b). FGM is part of a patriarchal power structure, which legitimises the need to ensure women's virginity, marriageability, fidelity and control of reproduction (Coomaraswamy, 2002b). FGM is maintained by force in contexts where women's attempts to transgress societal expectations result in severe consequences (Dorkenoo, 1994; Hosken, 1979; Momoh, 2005). In the same vein, *consent* to FGM when subject to familial and community pressure is highly questionable (Chambers, 2008; Gunning, 1991: 190). Women's experiences of FGM highlight that FGM has negative psychological and physical health consequences (Gordon, 2005; Toubia, 1994). In conclusion, FGM is a practice that perpetuates women's inequality and therefore requires prohibition¹³⁰.

It is often argued that the human rights approach emphasising law and punishment in eliminating violence against women and girls is ineffective and emphasis should instead be

¹²⁸ See, Hicks (1996), Daly (1990) and Hosken (1979), Jeffreys (2005), Weil Davis (2002) and Duits and Van Zoonen (2006).

¹²⁹ There are no comparable practices performed on boys and men that seek to curtail their sexuality to the advantage of the opposite sex.

¹³⁰ The question of how best to achieve elimination is discussed further in the conclusion.

placed on education, community and health initiatives (Coomaraswamy, 2002b: 31; Gunning, 1991). However, Coomaraswamy (2002b) highlights that law has had an impact on changing the normalisation of gender-based violence over time. For example, marital rape used to be legal and acceptable, but now it is prohibited and regarded by society as a criminal offence. As demonstrated in the empirical chapters five and six, anti-FGM legislation does have a role in encouraging parents and family members to abandon the practice due to fears of criminal sanctions. I argue for increased state responsibility to eliminate FGM with effective legislation that is implemented rather than merely appearing on the statute book. Alongside legislation, grass-roots initiatives are required, including health and education community programmes that can change ingrained cultural practices to the detriment of girls and women.

Throughout the thesis I have applied a multi-disciplinary approach of intersectionality, which emerged from critical race studies in the 1980s and 1990s. The aim is to analyse the ways in which race, gender, culture, class, nationality and religion interact in shaping ethnic minority women's experiences of FGM and the law (Crenshaw, 1991: 1244). This involves factoring in the multiple layers of discrimination that heighten women's vulnerability and experience of FGM and the law (Ertürk, 2009: 42; Nash, 2008). Women described their experiences of structural and legal discrimination on gender, racial, class and cultural grounds, which impacted upon their attitudes and beliefs towards attempts to eliminate FGM. When developing legislation that aims to eliminate FGM it is important that the law accounts for the discrimination that women experience when accessing the criminal justice system and how this operates as a barrier to women seeking support. At present the law has not been designed from an intersectional perspective, as it fails to recognise women's unique identities and different experiences of FGM. The law approaches FGM as a monolithic issue and essentialises women.

Questioning the Core Motivations for Female Genital Mutilation

This study focused on women's experiences as a means of providing knowledge and assisting in building upon theoretical perspectives about FGM. Chapter four explored women's experiences of FGM and women's and stakeholders' attitudes towards the motivations for the persistence of the practice. The empirical data from 79 interviews with women and stakeholders and two focus groups with women showed the broad motivations for performing FGM, which depend on individual, familial and community perspectives. Key motivations included control of girls and women's sexuality, preservation of a cultural practice and

religious beliefs. I argue that the dominant ideology underpinning the persistence of FGM is the regulation and control of girls and women's sexuality.

A feminist analysis¹³¹ of the data showed that patriarchal power structures define sexual norms for girls and women. Girls must be virgins until marriage, once married they must remain faithful and reproduction must be tied to marriage. FGM is performed to ensure these norms are maintained. I argue that transgressing social norms threatens patriarchal society, therefore the consequences of nonconformity are severe, including ostracisation and isolation. Ideological beliefs and practice that sustain unequal power relations between men and women is a form of violence against women and girls, and therefore a human rights violation (Ertürk, 2009). In contrast, African women scholars¹³² prioritise culture or group rights to maintain the traditional practice of FGM.

While women provided rich and complex understandings of the motivations for FGM, stakeholders held reductive attitudes towards the practice. They universally framed FGM as a means of controlling girls and women's sexuality. Stakeholders described women as victims of oppression and they depicted other cultures and Islam as uncivilised and a threat to the West. The sensationalist language used by stakeholders to describe FGM threatens to undermine attempts to change communities' attitudes and beliefs and eliminate FGM. Evidence shows that stakeholders need a better understanding of FGM-performing communities and how their experiences of gender, race, culture and integration impact upon their attitudes towards FGM. This might help stakeholders combat the practice and assist them in getting more support from within communities themselves.

Exploring why Female Genital Mutilation Persists in a Context of Criminalisation

In chapter five, findings from interviews with women and stakeholders highlight their attitudes and beliefs towards the criminalisation of FGM and the changing dynamics of the practice in response to anti-FGM laws. The data shows that women mainly supported a criminal offence of FGM when performed on children, but women were divided about the prohibition of FGM for adult women. At present, it is a criminal offence for FGM to be

¹³¹ See Hicks (1996), Daly (1990) and Hosken (1979), Jeffreys (2005), Weil Davis (2002) and Duits and Van Zoonen (2006).

¹³² See Obiora (2005), Ahmadu (2000), Njambo (2011) and Korieh (2005).

performed on adult women. The data showed that women were divided about whether family and community pressures to conform to engrained cultural practices undermine women's consent to FGM. Some women argued adult women exercise their agency and consent to FGM (Meyers, 2000).

However, I side with the feminist framework employed by Sandra Bartky (1997) who argues that it is important to analyse why women make choices and the social influences that women are subjected to when making choices. As identified in chapter four, the motivations for FGM are to control girls and women's sexuality. Bartky (1997) argues that disciplinary practices designed to produce a docile body are maintained by violent social sanctions imposed when women transgress social norms (30). Applying this theory to FGM, women experience social sanctions in the form of isolation from their family and community and stigmatisation if they refuse to conform and undergo FGM. While a feminist analysis supports criminalising FGM, the law cannot change the attitudes of women who support the practice. Grass-roots level initiatives are required to change mindsets.

As identified in chapter one, FGM is defined by international human rights law as a violation of the rights of the child and the UK government defines FGM as child abuse (Dustin & Phillips, 2008: 417; House of Commons Home Affairs Committee, 2014). During the interviews women described in visceral detail FGM performed on their bodies when they were children and the physical and psychological harm they experienced as a result. While women were divided about defining FGM as child abuse, the descriptions they provided of FGM reaffirm that child abuse is an accurate definition of the practice. However, applying the label of child abuser to parents and relatives is a complex matter. The empirical data shows women vehemently reject the label of child abusers. As identified in the literature review and in the interviews, perpetrators believe they are performing an act of love rather than inflicting child abuse (Boulware-Miller, 1985; Dustin & Phillips, 2008; Gunning, 1999; Shweder, 2000). There are two possible consequences of invoking the label of child abuse: it could change attitudes and behaviour, or it could have the adverse effect of rousing tensions and hostilities within communities who then resist the label and reinforce the practice underground. The findings suggest women's resistance towards labelling communities as child abusers is the most likely outcome.

Stakeholders' attitudes and beliefs towards the criminalisation of FGM could impact upon the enforcement of anti-FGM laws. The different approach taken by stakeholders in dealing with cases of FGM highlights the need for a mainstreamed legal response that compels frontline stakeholders across sectors to work together. The data shows stakeholders continue to be

reluctant to intervene due to concerns about being branded racist (Erica Burman, 2005). Evidence from the data supports the need for the current offence of a duty of regulated professions to notify the police of FGM (section 5B FGM Act 2003). Stakeholders who work in a regulated profession¹³³ could be prosecuted if they discover FGM has been carried out on a girl under the age of 18 and they fail to notify the police. However, the offence does not go far enough in preventing FGM and protecting adult women. The law does not place a duty on stakeholders to report cases where girls and women are at risk of FGM or where adult women have disclosed they have been cut. If a preventative approach through legislative intervention is not introduced, girls and women will continue to be left without protection.

The empirical study provided a valuable contribution to the literature in identifying the changes to the dynamics of the practice. The findings in chapter five show that stakeholders are aware of the changes to the dynamics of the practice to avoid detection and prosecution. The international context of FGM combined with doctors performing FGM on younger girls and the type of FGM changing to lesser physically invasive types of FGM work to avoid detection. Changes to the way FGM is performed serve as barriers to the enforcement of legislation. Even innovative and progressive laws will struggle to deter and prosecute FGM when the practice is pushed further underground.

Breaking Down the Barriers that Prevent the Implementation of Anti-Female Genital Mutilation Laws

The study explored the key barriers to anti-FGM laws deterring and preventing FGM. Interviews with stakeholders involved in the enforcement of law, and with women who sought to avoid detection, provided insights into the barriers of anti-FGM laws working effectively. The empirical data in chapter six sets out women's and stakeholders' experiences of anti-FGM laws.

Findings showed that women and stakeholders believe that a lack of education about FGM and anti-FGM laws amongst communities is a barrier to the law deterring and preventing FGM. Indeed, the data confirms that many women are unaware that FGM is a criminal offence, while stakeholders lack training about FGM. FGM is an invisible practice rarely discussed in the public sphere, thus women are unaware of anti-FGM laws and stakeholders lack confidence in dealing with cases of FGM. Feminists have long advocated for bringing

¹³³ Health care stakeholder, teacher or social care worker.

the private into the public (Bunch, 1990; MacKinnon, 1989). Contextualising feminist theory within FGM debates, education is a means of breaking taboos by discussing and debating FGM in the public and raising awareness. If women are educated about FGM and the law, the law could have a role in changing attitudes, beliefs and behaviours.

Data showed that racial divisions constitute a significant barrier to the law functioning effectively. FGM is a unique offence, as the law is designed by the political elite who have no experience or knowledge of FGM and projected upon marginalised immigrant communities (Winter, 1994: 940). Findings show that women believe anti-FGM laws provide a means for law enforcement agents to *legitimise* the surveillance of immigrant communities. Women linked anti-FGM laws to broader structures of oppression within the criminal justice system, such as sexism and racism, which deter them from accessing support. Women fear contacting the police as they could be subjected to racist treatment, as well as confirming racist stereotypes of immigrant communities as child abusers (Sokoloff & Dupont, 2005). Rather than relying on law enforcement agents, grass-roots level initiatives run by women from FGM-performing communities could encourage women to abandon FGM.

In contrast, stakeholders failed to understand women's experiences of structural sexism and racism and how this would deter them from accessing support from the criminal justice system. Stakeholders described experiencing "race anxiety" as they feared intervening in cases of FGM because they could be branded racist. Stakeholders prioritised their concerns about being labelled racist over helping and supporting vulnerable girls and women at risk of FGM (Maynard & Winn, 1997: 181). Stakeholders now have a legal duty to notify police of FGM. This is an important legal measure designed to compel stakeholders to intervene in such cases.

A theme running throughout the interviews was the legal double standard that permits FGCS while prohibiting FGM. Findings from interviews with women and stakeholders confirmed that the legal double standard is an obstacle to anti-FGM laws deterring and preventing FGM. The permissibility of FGCS is an effective advocacy tool for women arguing for the same legal treatment for FGM. It also provides an avenue for FGM to be performed under the guise of FGCS thereby subverting the law. Invoking a feminist theoretical analysis, feminists linked the practices of FGM and FGCS to show that control of women's sexuality persists on a global scale and is not confined to immigrant communities (Davis, 2004; Greer, 1999; Weil Davis, 2002). All patriarchal cultures pressurise women to conform to bodily expectations. I argue that FGCS and FGM exist on a continuum of violence against women. Women experience cultural pressures of varying degrees to undergo genital surgery. Some women

experience pressure from media advertisements to have a ‘designer vagina’ while other women are threatened with familial isolation if they refuse to undergo FGM. Both practices stem from cultural pressures of different degrees. Drawing on a feminist analysis, I argue that FGCS and FGM should both be reconceptualised and defined as harmful to women thus inviting legal prohibition (Jeffreys, 2005).

Law and Policy Recommendations

The findings of the study suggest law and policy recommendations which largely support the conclusions of the report by the House of Commons Home Affairs Committee (2014) and the Bar Human Rights Committee (2014).

Legal Changes

1. I propose amending existing legislation, the Female Genital Mutilation Act 2003 to prevent the existence of the current loophole of FGCS. At present FGCS is permitted on the basis that genital surgery is necessary for a woman’s physical or mental health, which is an exemption to anti-FGM legislation. To prevent the double standard, I propose removing section 1(2)(a) and section 1(5), which would prohibit FGM and/or FGCS from being performed on grounds of physical or mental health.
2. I propose amending the wording of the Female Genital Mutilation Act 2003, as it currently refers to “girls,” however “girl includes woman” according to section 6(1). Referring to girls throughout the 2003 Act infantilises women, as the law also applies to adults. A simple change to the language of the Act to state girl and woman reflects the status quo of the legislation.
3. I propose amending Section 5B of the Female Genital Mutilation Act 2003 to compel a person who works in a regulated profession in England to notify the police if, in the course of his or her work in the profession, the person discovers that FGM has been carried out on a girl who is aged under 18 or woman aged over 18. I propose this recommendation while recognising that further research is required and it could have the consequences of putting patient confidentiality at risk and driving the practice underground. The introduction of this offence is necessary *because* medical practitioners are the most likely group to encounter women and girls affected by FGM and without reports of FGM, the practice will continue without impunity.

4. A further offence should be introduced to place a duty on regulated professions to notify social services of a girl or woman who is at risk of FGM. Amending the offence in this way would place a duty on stakeholders to report cases of FGM on adult women and report cases where girls and women are at risk of FGM. As identified in a report by House of Commons Home Affairs Committee (2014), stakeholders should be referring women to social services when they have been cut and they give birth to a girl, as there is an obvious risk to a girl that should be investigated (50). At present medical stakeholders do not always refer cases to social services as they do not want to breach patient confidentiality, however such concerns should not prevent practitioners from making a referral where a child is at risk (House of Commons Home Affairs Committee, 2014: 50).
5. There needs to be an international commitment to criminalising FGM across the globe to prevent loopholes that allow women and girls to be taken from England and cut abroad. For example, FGM is medicalised in Indonesia and performed in government-run hospitals in Egypt and Dubai (Coomaraswamy, 2002b).

Policy Proposals

1. FGM will continue to persist until communities abandon the practice. The government must invest funding in community initiatives to challenge the practice over a long-term duration across the country.
2. Regulated professions, including the police, health, education and social services require mandatory training about FGM and anti-FGM laws to ensure they are aware of how to deal with cases of FGM and to avoid fears of 'race anxiety' arising. They are in the best position to detect warning signs that a girl is at risk of FGM or has already undergone FGM, thus it is vital they are aware of the indicators (House of Commons Home Affairs Committee, 2014: 50).
3. Further funding for shelters and support services aimed at girls and women at risk of FGM are required to provide girls and women with viable means of escaping FGM.

4. FGM should be introduced on the national curriculum and taught to girls and boys in all schools as a means of preventing and raising awareness amongst mainstream society and immigrant communities.
5. At present the Department of Health collects data on women who have been through FGM and are treated by the National Health Service. This should be continued and expanded by collecting data and statistics across all clinics, whether public or private.
6. Introduce a universal system of mandatory health examinations of children (boys and girls) at school. This would assist in preventing FGM and safeguarding girls without stigmatising FGM-performing communities. Examinations would assist in detecting other health conditions that children suffer from. The use of regular examinations of all children in France has been a key factor in obtaining evidence that has resulted in a large number of prosecutions (House of Commons Home Affairs Committee, 2014: 48). While such a scheme would engage Article 8 of the European Convention of Human Rights, a right to private and family life, I would argue that any interference with Article 8 is justified and proportionate, as it can deter child abuse and safeguard children who have been cut.
7. The discourse and language used by the media and the government when discussing FGM needs to be carefully monitored to ensure the issues are not sensationalised and communities are not labelled and stigmatised as barbaric child abusers. The impact of such rhetoric can have the adverse effect of reinforcing rather than eliminating FGM.

Further Research Suggestions

This study provides a contribution to the literature in exploring women's experience of FGM and their attitudes and beliefs towards anti-FGM law and stakeholders' attitudes towards the challenges and potential of legislation. The findings of this study show that FGM is a persistent practice despite anti-FGM laws in England. Significant practical barriers prevent anti-FGM laws functioning effectively. The need for education, support from stakeholders and legislative changes are key to providing girls and women with protection from FGM in England. Only a handful of qualitative studies about FGM in England have been conducted. No studies have undertaken 79 interviews with women and stakeholders and focus groups with women. This study has contributed to filling a gap in the literature of empirical data.

However, further research is required in England and other countries to understand the complex international matrix of the practice and whether innovative methods to eliminate FGM across borders could be developed. Quantitative research about the prevalence of the practice in England is needed to understand the dynamics and demographics of FGM and how to develop strategies to deal with the practice. Furthermore, research that explores the international dynamics of FGM with girls being taken from England to be cut abroad could assist in developing policy to target such practices. It is also important to develop understandings of how the practice is viewed across generations and different demographic groups. Such information could be beneficial in assisting stakeholders, NGOs or community projects to target groups that are likely to continue the practice. As a lack of education and awareness of women's rights and services available was identified as an obstacle to women and girls seeking support, further research could assess the best possible avenue for raising awareness.

Further research about medical practitioners attitudes towards FGM is imperative. Medical professionals are the most likely group of practitioners to come across women and girls affected by FGM and there is now a legal duty on them to report cases to the police. However, it is not clear whether medical practitioners will comply with the legal duty due to concerns that it conflicts with patient confidentiality. This could be explored in further research.

Law and policy relating to FGM has changed frequently since the introduction of the first legislation in 1985. In an environment where law and policy is fluid, ongoing research is required to understand the efficacy of such measures. However, research of women's experiences would have to factor in the vulnerability of participants and the challenges of locating interviewees. More pressing is the monitoring of the implementation of anti-FGM laws, which would assist in addressing potentials, challenges and proposals for change in the arena of law and policy and contribute to an understanding of how stakeholders seek to implement the law. This would include research throughout the nation to assess local variations in women's access to the law and support services.

Finally, while the focus of this study has been on criminal legislation, further research exploring the impact of women's experiences of FGM in the context of having no immigration status in England could be explored further. As a barrister, I have represented women who have sought asylum in England because they fear persecution (FGM) in their home country. While some women are successful in gaining asylum, other women's applications and appeals are unsuccessful. Globalisation is likely to result in increasing

numbers of women seeking refuge in England on grounds of FGM. With no social security, basic service provision systems and an anti-immigration sentiment, women's experiences of leaving situations where they face FGM to access to safety and support in England need to be explored.

Concluding Observations

The government has re-examined anti-FGM law over the years to deal with lacunas in legislation and increase the likelihood of prosecutions and convictions. Despite such changes, there has not been one conviction for FGM and the practice continues to persist in England. It is not acceptable that girls and women continue to be at risk of FGM without support from stakeholders. When girls and women are left at risk of FGM, the state prioritises cultural and racial sensitivities over the protection of human rights. The barriers to the law functioning effectively as identified in this study could be remedied with a national action plan led by the government. With anti-immigration rhetoric increasing in England, there is less political will to support immigrant communities with practical and effective measures to protect vulnerable girls. Instead, there has been a move towards a right-wing discourse that uses FGM as a means of labelling immigrant communities as barbaric. Framing FGM as a cultural issue leaves stakeholders fearful of intervening, as they could be labelled racist. Furthermore, communities resist quasi-racist anti-FGM initiatives and continue to perform the practice underground. Understanding FGM requires examining the practice from an intersectional perspective and removing reductive links to culture from anti-FGM discourse and legislation.

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Appendix I:

Table of Focus Groups with Women Participants

Focus group No	Location	No of participants	Country of origin	Interpreter
FG1	Leicester	11	Somalia	Yes
FG2	London	11	Somalia	Yes

Appendix II:

Table of Women Participants

Participant No	County of origin if known	Type of FGM if known	Employment [relevant if questioned about professional experience]	Type of interview
P1	Somalia	I	NGO worker	In person and by phone
P2	Zimbabwe	IV	NGO worker	In person and by phone
P3	Gambia	III	NA	By phone
P4	Kenya, Massai Tribe	I	NA	By phone
P5	Somalia	Unknown	NA	By phone
P6	Nigeria	Not undergone FGM	NA	By phone
P7	Somalia	Unknown	NA	By phone
P8	Somalia	Not undergone FGM	NA	In person and by phone
P9	Mali	Unknown	Midwife	By phone
P10	Sierra Leone	Type II	Social worker	By phone
P11	Unknown	Unknown	NGO worker	By phone
P12	Somalia	Type III	Teacher	In person
P13	Somalia	Type III	Nurse	By phone

Appendix III:

Table of Male Participants

Participant No	County of origin if known	Type of interview
P14	Ghana	By phone
P15	Nigeria	By phone

Appendix IV:

Table of Stakeholder Participants

Participant No	Organisation as noted in interview tag	Role	Type of interview	Gender
P16	Department of Health	Civil servant working to amend and enforce legislation.	In person	F
P17	Home Office	Civil servant working to amend and enforce legislation.	In person	F
P18	Department for International Development	Civil servant working with NGOs internationally to eliminate FGM.	In person	F
P19	Department for Education	Civil servant working to amend and enforce legislation.	In person	M
P20	Local Authority in the North of England	Established an FGM forum collaborating with professionals working with communities to share information.	In person	F
P21	Member of the House of Lords	Government ministerial role when the Prohibition of Female Circumcision Act 1985 was implemented. Role involved scrutinising legislation.	In person	M
P22	Member of the House of Lords	Shadow ministerial role when the Serious Crime Act 2015 was implemented. Role involved amending legislation.	In person	F
P23	Member of the House of Lords	Scrutinised the Serious Crime Act 2015 and lobbied the government to introduce an offence of encouraging FGM in 2015, which was not successful.	In person	F
P24	Member of the House of Lords	Government ministerial role when the Prohibition of Female Circumcision Act 1985 was implemented. Role involved scrutinising legislation.	In person	F
P25	Member of the House of Lords	Involved in the implementation of the Prohibition of Female Circumcision Act 1985. In addition, P25 was a British representative for the UN status of women 1982 to 1988.	In person	F
P26	Member of the House of Lords	Involved in scrutinising the Prohibition of Female Circumcision Act 1985 and the Female Genital Mutilation Act 2003.	In person	F
P27	Member of the House of	Anti-FGM campaigner who timetabled debates about FGM in the House of	In person	M

	Lords	Lords.		
P28	Member of Parliament	Instrumental in proposing and ensuring the implementation of the Female Genital Mutilation Act 2003.	By phone	F
P29	London Assembly Member	Anti-FGM campaigner since 1980 and former midwife who worked closely with FGM-performing community members.	In person	F
P30	Member of Parliament	Member of the Public Bill Committee when the Serious Crime Act 2015 was implemented.	By phone	M
P31	Member of Parliament	Former Home Office minister, which involved improving the government response to FGM.	By phone	M
P32	National Health Service (NHS)	Midwife working with women affected by FGM and women and girls at risk of the practice.	By phone	F
P33	NHS	Midwife working with women affected by FGM and women and girls at risk of the practice.	In person	F
P34	NGO	Works for an NGO specialising in FGM and provides support to FGM-performing communities.	In person	F
P35	NHS	Midwife working with women affected by FGM and women and girls at risk of the practice.	By phone	F
P36	NHS	Midwife working with women affected by FGM and women and girls at risk of the practice and working with FGM national clinical group.	By phone	F
P37	General Medical Council	Advisor in standards and ethics team assisting medical professionals working with women and girls who have undergone FGM or are at risk of FGM.	By phone	F
P38	NHS and Member of the House of Lords	Involved in scrutinising the Prohibition of Female Circumcision Act 1985 and worked with women and girls affected by FGM as a former doctor.	In person	M
P39	NHS	Obstetrician and gynecologist working with girls and women affected by FGM.	In person and by phone	F
P40	NHS	Obstetrician and gynecologist working with girls and women affected by FGM.	By phone	F
P41	NHS	Consultant paediatrician in child protection clinic working with girls affected by FGM.	By phone	F
P42	NHS	Obstetrician and gynecologist working with girls and women affected by FGM.	By phone	F

P43	NHS	Consultant obstetrician and gynecologist working with girls and women affected by FGM.	In person	F
P45	Mosque in Cambridge	Imam advising on Islamic scripture relating to FGM.	In person	M
P46	Chambers in London	Leading criminal barrister involved in the first and only FGM prosecution.	In person	M
P47	Chambers in London and Ministry of Justice	Leading criminal barrister and member of the judiciary with experience of FGM.	In person	M
P48	Chambers in London	Senior criminal barrister involved in the first and only FGM prosecution.	By phone	F
P49	Chambers in the North of England	Leading family law barrister involved in a family law case of FGM.	By phone	M
P50	Chambers in the North of England	Senior family law barrister involved in a family law case of FGM.	By phone	M
P51	Chambers in the North of England	Leading family law barrister involved in a family law case of FGM.	By phone	M
P52	Ministry of Justice	Member of the judiciary with experience of FGM.	In person	F
P53	Chambers in London	Senior family law barrister involved in a family law case of FGM.	By phone	M
P54	Law Firm in France	Senior lawyer in France with extensive experience prosecuting parents and cutters in cases of FGM.	In person and by phone	F
P56	Local Authority in London	Children's safeguarding and development officer working with the voluntary community and faith sector ensuring they have child safeguarding policies relating to FGM.	By phone	F
P57	NSPCC	Policy advisor with experience of FGM cases.	By phone	F
P58	Consultant for NGOs	Working with NGO organisations to research FGM and launch anti-FGM programmes internationally.	In person	F
P59	NGO	Working with FGM-performing communities to encourage them to abandon FGM.	By phone	F
P60	NGO	Working with FGM-performing communities to encourage them to abandon FGM.	By phone	F
P61	NGO	Working with FGM-performing communities to encourage them to abandon FGM.	By phone	F
P62	NGO	Feminist activist and advocate focusing on women's rights violations.	By phone	F
P63	NGO	Working with women and girls from FGM-performing communities to encourage them to abandon FGM.	By phone	F

P64	NGO	Working with women and girls from FGM-performing communities to encourage them to abandon FGM.	By phone	F
P65	NGO	Working with faith leaders to encourage them to advocate for eliminating FGM.	In person	F
P66	Undisclosed Police Constabulary	Police officer involved in investigating cases of FGM and referring cases to the crown prosecution service.	By phone	M
P67	Undisclosed Police and Crime Commissioner	Working for the Police and Crime Commissioner and assisting in advising the police regarding FGM cases.	By phone	F
P68	Crown Prosecution Service	Advises on prosecuting cases including FGM cases.	By phone	F
P69	Crown Prosecution Service	Advises on prosecuting cases including FGM cases.	By phone	M
P70	Crown Prosecution Service	Advises on prosecuting cases including FGM cases.	By phone	F
P71	Crown Prosecution Service	Advises on prosecuting cases including FGM cases.	By phone	M
P72	Private Health Clinic	Cosmetic surgeon who has worked with women that have undergone FGM.	In person and by phone	M
P73	Private Health Clinic	Cosmetic surgeon who has worked with women that have undergone FGM.	In person and by phone	M
P74	British Association for Social Workers	Advises on how social workers should deal with cases of FGM.	By phone	M
P75	Social Worker at Undisclosed Local Authority	Deals with cases of FGM where girls are at risk of the practice.	By phone	F
P76	Undisclosed School	Head teacher of a primary school working with girls affected by FGM.	By phone	F
P77	Undisclosed School	Head teacher of a primary school working with girls affected by FGM.	By phone	F
P78	Undisclosed School	Teacher at a primary school working with girls affected by FGM.	By phone	F
P79	Undisclosed School	Head teacher of a primary school working with girls affected by FGM.	By phone	F

Appendix V:

Participant Consent Form



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Department of Sociology

Charlotte Proudman

PhD Candidate

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07597569149

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Title of Project: The Impact of Criminalisation on Female Genital Mutilation in England
From the Perspective of Women and Stakeholders

Name of Researcher: Charlotte Proudman

As part of a research project I am conducting interviews and focus groups. You will be asked questions about female genital mutilation. This research is being conducted as part of a PhD thesis. The interview will last around 20 minutes. The focus group will last around 1.5 hours. Please feel free to stop the interview at any time if you do not feel comfortable or would like to take a break. If you are interested in receiving further information about this project, please send me an email at cb672@cam.ac.uk

Please tick box

1. I confirm that I have understood these instructions and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐

3. I understand that my responses will be anonymised and only used for academic research.

☐

4. If during the interview a person or child is identified as being at risk of female genital mutilation or at risk of another criminal offence I will report this information to the police.

☐

4. I understand that the interview / focus group was recorded

☐

5. I agree to take part in the above project.

☐

Name of Participant

Date

Signature

Charlotte Proudman
Name of Researcher

Appendix VI:

Interview Question Prompts for FGM-Performing Community Members

1. What do you think to the term female genital mutilation?
2. What do you think younger Somali girls who have been brought up in the UK think of female circumcision?
3. In your community how is female circumcision viewed by:
 - a. Men and women
 - b. Older and younger people
 - c. Educated and non-educated
 - d. People born in the UK v people born in their country of origin
4. Who decides whether a girl should be cut?
5. In your community what reasons do people give for female circumcision?
6. What reasons do people give for not cutting?
7. How are girls and women in your community treated if they are not cut?
8. What do people say actually happens during female circumcision:
 - a. Who does it
 - b. How does it occur
 - c. Where does it occur
 - d. When does it occur
 - e. What stories do people hear about the experience
9. Have you come across labia elongation, pricking, piercing, incising, scraping and cauterization?
10. What do people say about the effects of female circumcision on women's:

- a. Emotional well-being and psychological
 - b. Physical well being/health
 - c. Sexual well being/health
11. What do people say about finding good help and information on female circumcision?
- a. Is it easy to find
 - b. Is it difficult to find
 - c. Where do they get it from
 - d. How could this be done better
12. What do people say about being de-infibulated and re-infibulated (when you're re-stitched up):
- a. Who does it
 - b. How does it occur
 - c. Where does it occur
 - d. When does it occur
 - e. What stories do people hear about the experience
13. Have you come across type IV female genital mutilation: pricking, piercing, incising, scraping, stretching and cauterizing the genital area?
14. Have you come across female genital cosmetic surgery?
15. Do you believe female circumcision should be a criminal offence:
- a. For consenting adults
 - b. For children whose parents consent on their behalf
16. Are communities aware that female circumcision is a criminal offence?
17. In your view, what effect do you think prosecutions for female circumcision will have on the practice?

Appendix VII:

Interview Question Prompts for Stakeholders

1. When did you first get involved in female genital mutilation work?
2. What do you think are the key motivations for communities performing female genital mutilation?
3. Have you experienced a backlash in speaking out against female genital mutilation?
4. Do concerns about being labeled “racist” impair professionals’ child protection duties?
5. Have you come across type IV female genital mutilation? Do you believe it should be a criminal offence?
6. Do you believe female genital mutilation should still be a criminal offence even if:
 - a. adults consent to female genital mutilation; and
 - b. parents consent on behalf of their children.
7. Is there a distinction between female genital mutilation and female genital cosmetic surgery?
8. There are currently no convictions for female genital mutilation why do you think this is?
9. Do you think there has been a failing in the medical profession in reporting female genital mutilation?
10. What are your views about:
 - a. Mandatory health checks at school for children from communities perceived to be at risk

- b. Mandatory health checks at school for all children
- c. Police working closely with affected communities
- d. Schools identifying children at risk
- e. Make reporting of female genital mutilation mandatory

11. Is law the most appropriate instrument to change affected communities' attitudes and beliefs towards female genital mutilation?
12. Should the police and public bodies work with community leaders?
13. How involved were the police and other public bodies in responding to female genital mutilation in the late 1980s and early 1990s?
14. Are community members aware that female genital mutilation is a criminal offence?
15. In your view what effect do you think prosecutions for female genital mutilation will have on the practice?
16. What more should be done to combat to female genital mutilation?

Appendix VIII:

Definitions and the Meaning of Abbreviations

Deinfibulation “refers to the practice of cutting open a woman who has been infibulated to allow intercourse or to facilitate childbirth.”¹³⁴

FC – Female Circumcision

FGCS – Female Genital Cosmetic Surgery

FGM – Female Genital Mutilation

MP – Member of Parliament

NGO – Non-government Organization

NHS – National Health Service, which exists throughout the UK

Pharaonic / pharaoni – Type III FGM

Reinfibulation “is the practice of sewing the external labia back together after deinfibulation.”¹³⁵

Sunna – Type I FGM

UN – United Nations

UNESCO – United Nations Economic and Social Council

¹³⁴See United Nations Population Fund, female genital mutilation frequently asked questions <http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions> [Accessed 02.05.2017]

¹³⁵*Ibid.*

UNICEF – United Nations International Children’s Emergency Fund

WHO – World Health Organization

Appendix IX: FGM Global Prevalence Map

